NORMAN REGIONAL HOSPITAL AUTHORITY
November 26, 2016
5:30 p.m.
Norman Regional Hospital
901 N. Porter
2nd Floor Board Room

A G E N D A

I. Call to Order ..... *Ms. Campbell*

II. Introduction and Recognition of Outstanding Employees ..... *Ms. Campbell*

A. Employee of the Month December 2012 – Kent Endersby, Health Information Technology Physician Liaison – John Meharg, Director Health Information Technology

III. Approval of the October 22, 2012 Board Meeting Minutes

ACTION NEEDED: Approve or Amend Minutes as Circulated

ACTION TAKEN: _____

IV. Performance Updates ..... *Dr. Smith/Mr. McAdams*

ACTION NEEDED: None, Information Item Only

V. Approval of the October 2012, Norman Regional Health System Financial Statements ..... *Mr. Hopkins*

ACTION NEEDED: Approve or Disapprove the October 2012, NRHS Financial Statement

ACTION TAKEN: _____

VI. Medical Staff ..... *Dr. Whalen*

A. Report from the November 13, 2012 General Medical Staff Meeting

1) Proposed Changes to the NRHS Medical Staff Bylaws

ACTION NEEDED: Approve or Disapprove the Changes to the NRHS Medical Staff Bylaws as approved at the November 8th General Medical Staff Meeting

ACTION TAKEN: _____

B. Report from the November 14, 2012 Medical Executive Committee Meetings

ACTION NEEDED: None, Information Only

1) Recommend the Proposed Emergency Medicine Privileges Revisions Regarding Family Medicine Fellowship in Emergency Medicine Supervision Requirements

ACTION NEEDED: Approve or Disapprove the Proposed Emergency Medicine Privileges Revisions Regarding Family Medicine Fellowship in Emergency Medicine Supervision Requirements as Recommended by the Medical Executive Committee

ACTION TAKEN: _____

VII. Report from the October 2012 Quality and Safety Committee ..... *Ms. Campbell*

ACTION NEEDED: None, Information Only

VIII. Operations Committee ..... *Dr. Anderson*

A. Report from the November 12, 2012, Operations Committee.....

ACTION NEEDED: None, Information Item Only

IX. Finance Committee ..... *Dr. Burcham*

A. Report from the a November 19, 2012, Finance Committee

ACTION NEEDED: None, Information Item Only

B. Recommend Capital Equipment Purchase Request .....

ACTION NEEDED: Approve or Disapprove Capital Equipment Purchase Requests as Recommended by the Finance Committee

ACTION TAKEN: _____

X. Establish Dates and Times for 2013 Authority Meetings..... *Ms. Campbell*

Section 933 of the Oklahoma Open Meeting Act requires the Authority to submit the date and time of its regular meetings for the coming calendar year. NRHA meetings have been scheduled for 5:30 p.m. on the fourth Monday of the month this past year. The schedule below describes similar dates and times for the Authority's monthly meetings in 2013

Note: *Because the fourth Monday in May is Memorial Day, the proposed meeting date is Tuesday, May 28, 2013. **Christmas falls on Wednesday this year, the proposed meeting date is Monday, December 16, 2013.

January 28	April 22	July 29	October 28
February 25	*May 28	August 26	November 25
March 25	June 24	September 23	**December 16

ACTION NEEDED: Approve or Modify the Proposed Dates & Times for the 2013 Authority Meetings

ACTION TAKEN: _____

XI. Old Business ..... *Ms. Campbell*

XII. New Business:

2012 Annual Compliance Report

ACTION NEEDED: Accept or Modify the 2012 Annual Compliance Report

ACTION TAKEN: _____

XIII. Administrative Report ..... *Mr. Whitaker*

ACTION NEEDED: None, Information Item Only

XIV. Proposed Executive Session. ..... *Mrs. Campbell*

A. Proposed Vote to Convene an Executive Session to Discuss with Legal Counsel Pending Internal Peer Review/Credentialing Investigations Regarding the Medical Staff Members/Applicants Listed Below Pursuant to 25 Okla. Stat. § 307.B. 4

ACTION NEEDED: Move to Convene into Executive Session to Discuss with Legal Counsel the Above Referenced Items

ACTION TAKEN: _____

B. Approve or Disapprove the Medical Staff Recommendations Regarding the Physicians as Listed in XIV B (1-5) Below

1. Recommend Medical Staff Reappointments:
   a) Carrie Barton, MD, Active Staff – Emergency Medicine Department
   b) Wayne Berryhill, MD, Active Staff – Surgery Department
   c) M. Edmund Braly, DDS, Active Staff – Surgery Department
   d) TaySha Howell, MD, Active Staff – Emergency Medicine Department
   e) Mudassir Nawaz, MD, Active Staff – Medicine Department
   f) Vytautas Ringus, MD, Active Staff – Surgery Department
   g) Steven Schultz, MD, Active Staff – Surgery Department
   h) Robert Arthur, MD, Consulting Staff – Medicine Department
   i) Anupa Khastgir, MD, Consulting Staff – Medicine Department

j) Charles Mirabile, MD, Consulting Staff – OB/Gyn Department
k) John Stanley, MD, Consulting Staff – OB/Gyn Department
l) Lorry Krous, MD, Courtesy Staff – Pediatrics Department
m) Phillip Dawkins, APRN-CRNA, Allied Health Staff – Anesthesia Dept.
n) Gregory Dinwiddie, PA-C, Allied Health Staff – Surgery Department
o) Darren Gose, APRN-CRNA, Allied Health Staff – Anesthesia Dept.
p) Daniel Matlock, APRN-CRNA, Allied Health Staff – Anesthesia Dept.

2. Recommend New Provisional Medical Staff Appointments
   a) Valerie Manning, DO, Active Affiliate Staff – Family Medicine Department

3. Recommend Appointments of Physicians in the Provisional Period:
   a) Brian Clowers, MD, Active Staff – Surgery Department
   b) Zakary Knutson, MD, Active Staff – Surgery Department
   c) Kelley Lobb, MD, Active Staff – Family Medicine Department
   d) Vanama Yerra, MD, Active Staff – Hospital Medicine Department
   e) Shoab Nazir, MD, Active Affiliate Staff – Medicine Department
   f) Lynsey Janzen, PA-C, Allied Health Staff – Cardiovascular Medicine Dept.
   g) Mathew Podany, RPA, Allied Health Staff – Radiology Department

4. Recommend Request for Change of Staff Category from Active to Active Affiliate
   a) Stephen Connery, MD, Family Medicine Department
   b) James Love, MD, Medicine Department
   c) Gary Ratliff, MD, Medicine Department
   d) Cynthia Taylor, MD, Family Medicine Department
   e) Elise Wiesner, MD, Medicine Department

5. Recommend Saboor Rashid, MD's Request for Supervised Emergency Medicine Privileges to Complete One-Year Fellowship in Emergency Medicine

C. Request to Adjourn Out of Any Such Executive Session and Return to Regular Session

ACTION NEEDED: Approve or Disapprove Adjournment of Any Executive Session and Return to Regular Session

ACTION TAKEN: _____

D. Proposed Vote to Approve or Disapprove the Medical Executive Committee Recommendations Regarding Credentialing of the Referenced Medical Staff Members [As Listed in XIV B (1-5)]

ACTION NEEDED: Approve or Disapprove the Medical Executive Committee Recommendations Regarding Credentialing of the Referenced Medical Staff Members [As Listed in XIV B (1-5)]

ACTION TAKEN: _____

XV. Board Open Discussion

XVI. Closing Comments…… *Ms. Campbell/Mr. Whitaker*

XVII. Adjourn

ACTION NEEDED: Motion to Adjourn the Meeting

ACTION TAKEN: _____

MISSION:

NORMAN REGIONAL HEALTH SYSTEM WILL PROVIDE QUALITY AND COMPASSIONATE HEALTH CARE SERVICES AND EDUCATION TO OUR REGIONAL COMMUNITY IN A RESPONSIVE, EFFICIENT, AND SAFE MANNER.

VISION:

NORMAN REGIONAL HEALTH SYSTEM WILL IMPROVE THE QUALITY OF LIFE IN OUR REGIONAL COMMUNITY.

2012-2013 STRATEGY STATEMENT:

NORMAN REGIONAL HEALTH SYSTEM WILL PROVIDE LEADERSHIP THROUGH THE DEVELOPMENT OF ACTION STEPS TO ACHIEVE AND BE RECOGNIZED AS THE HEALTH SYSTEM OF CHOICE FOR PATIENTS, PHYSICIANS, AND EMPLOYEES; THE HEALTHIEST REGIONAL COMMUNITY; AND THE HEALTH SYSTEM WITH THE BEST FACILITIES AND QUALITY OUTCOMES.

NORMAN REGIONAL HOSPITAL AUTHORITY
October 22, 2012

M I N U T E S

The Norman Regional Hospital Authority met in monthly session Monday, October 22,2012 at 5:30 p.m. in the Norman Regional Hospital Board Room. The meeting agenda was posted October 18, 2012 on the NRHS Website and at the south entrance of Norman Regional Hospital.

Members Present:	Robin Wiens Campbell, Chair Tom Clote, Vice Chair Muhammad Anwar, MD Russ McReynolds Don Sherman Jeff Burcham, OD Ann Way Carol Anderson, DO
Members Absent:	Elizabeth (Betsy) Gunn
Others Present:	Tom Whalen, DO, Chief of Staff David Whitaker, President/CEO Greg Terrell, Sr. VP/COO Ken Hopkins, VP/CFO Meegan Carter, VP/Revenue Cycle Nancy Brown, VP/CNO Sam McAdams, Manager Performance Improvement Karen Rieger, Crowe & Dunlevy Melissa Herron, Copywriter, Corporate Communications John Meharg, Director, Health Information Technology (HIT) ReJeanna Branch, Patient Access Advisor Terry Branch Melissa Bailey, Director of Patient Access
Recorder:	Doris Gonzalez, Executive Assistant

Agenda Item I. Meeting Called to Order

Ms. Campbell called the October 22, 2012, Norman Regional Hospital Authority meeting to order at 5:34 pm and thanked everyone for attending.

The minutes will reflect the order of discussion.

Agenda Item II. Introduction and Recognition of Outstanding Employees

Employee of the Month November 2012 – ReJeanna Branch, Patient Access Advisor, -- Melissa Bailey, Director Patient Access

Ms. Campbell introduced Ms. Melissa Bailey who introduced Mrs. ReJeanna Branch as the November 2012 Outstanding Employee of the Month. Ms. Bailey shared with the Board the employee's work accomplishments, dedication, commitment, positive attitude, and professionalism.

Mrs. Branch stated she was honored and thankful to have received this award.

Ms. Campbell congratulated and thanked Mrs. Branch on behalf of the Board for her outstanding service.

Mr. Branch, Mrs. Branch and Ms. Bailey left the meeting at 5:39 p.m.

Agenda Item III. Approval of the September 24, 2012 Board Meeting Minutes

Ms. Campbell entertained a motion to approve or amend the September 24, 2012 Board Meeting Minutes

ACTION TAKEN: The motion to approve the September 24, 2012 Board Minutes as submitted was made by Mr. Sherman. Mr. Clote seconded the motion and the minutes were unanimously approved with aye votes from Dr. Anderson, Dr. Burcham, Mr. Clote, Mr. McReynolds, Mr. Sherman, Ms. Way and Ms. Campbell.

Ms. Herron presented a video of Norman Regional Health System employees participating in the Medline "Pink Glove Dance" contest. The 1st prize is $10,000 to donate to a Charity of your choice (Susan G. Komen for the Cure). Go to "pinkglovedance.com" and vote for NRHS.

Agenda Item IV. Performance Updates

Mr. Sam McAdams, Manager of Performance Improvement, presented the monthly Clinical Quality Performance Updates. He highlighted the following:

- ✓ **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**
  Mr. McAdams reviewed the HCAHPS dashboard noting benchmarks were achieved in all domains except for a couple of area. Overall, the trends are improving.

- ✓ **LEAN Update**
  As of May 2011 there have been 59 staff trained. The current LEAN class has twenty-three employees that are looking at courier service efficiency and rental equipment tracking. Once employees are trained on how to use the LEAN tools, they will go back to their departments and start looking for areas of deficiencies we can improve. The goal is to have 32 staff members trained in FY 2013. There have been 45 LEAN projects to date with 13 completed, 23 ongoing and 9 discontinued. November 14, 2012 at 9 a.m., Board members are invited to attend a LEAN Class report in the NRH Auditorium.

Dr. Anwar joined the meeting at 5:47 p.m.

- ✓ **Quality Reporting Trends (CMS, Insurance Providers, etc.)**
  Mr. McAdams presented an overview of the Centers for Medicare & Medicaid Services Quality-Based Payment Initiatives report (Hospital Quality Data, Value Based Purchasing, Readmission, Hospital-Acquired conditions and Meaningful Use) noting it puts more than 7% of payment at risk by 2018. As of October 2012 CMS initiated a Hospital Based Inpatient Psychiatric Services (HBIPS) that NRHS will be required to submit quality information. This is all part of the Deficit Reduction Act.

  Blue Cross & Blue Shield has initiated a Blue Distinction Center that NRHS has submitted applications to part of their Cardiac Care, Bariatric Surgeries and Knee and Hip Replacement and will require quality reporting so they can categorize and show how we compare to other hospitals. More quality reporting is being emphasized.

- ✓ **Cardiac Registries**
  NRHS is participating fully in The Society of Thoracic Surgeons and the American College of Cardiology registries and are starting to receive preliminary reporting. This report gives the System a comparison as to how we are performing nationally.

Agenda Item V. Approval of the September 2012, Norman Regional Health System Financial Statement

Mr. Hopkins highlighted the following from the September 2012 NRHS Financial Statement:

- ✓ September's inpatient admissions were down 141 cases (9.4%) from August and 108 cases (7.4%) below budget.
- ✓ Average Length of Stay (ALOS) for acute cases improved .2 of a day from 3.8 in August to 3.6 in September. Net excess days saw similar improvement from 390 in August to 138 in September.
- ✓ September's outpatient admissions were down 9.6% from last month and about 6.6% below budget.

Weak volume was a key factor in September's performance, as seen by the change in the Gross Revenue, which was $4.9M below budget and $7.1M below the prior month. However, numerous other significant factors compounded this negative impact on Net Revenues. The other factors included:

- ✓ Recovery Audit Contractor (RAC) and Prepayment Audits have had a substantial negative impact in recent months. RAC alone identified approximately $2.1 million for recoupment in recent months.
- ✓ The Payer Mix in September was a higher than normal mix of government payers (Medicare and Medicaid) that had a substantial negative impact on the financial performance because of their much high discount levels.
- ✓ An unusually high number of very high-cost Medicaid cases recently, some of which will carry over into October or possibly beyond. An average Medicaid case would result in payment of 16-17% of charges whereas these high-cost cases will result in dramatically less.
- ✓ A significant drop-off in the Case Mix Index (CMI) that was probably driven by the weakened inpatient surgical volumes. Decreased CMI is an indicator for decreased reimbursement and usually manifests in higher contractual allowance percentage and weaker net revenue.

September 2012 Financial Performance

- Gross Revenue (Budget $111,101,798) $106,251,887
- Net Revenue (Budget $27,932,906) $25,172,890
- Expenses (Budget $27,641,233) $26,819,748
- Net Income from Operations (Budget $291,673) ..... -$1,646,858
- Non-Operating Income (Budget $378,805) $1,234,136
- Excess Income Over Expenses (Budget $670,478) ..... -$412,722
- Days in Accounts Receivable (Budget 49.0 days) ..... 54.2 days
- Days Cash on Hand (Budget 134.0 days) ..... 124.7 days

Mr. Hopkins noted the Maximum Annual Debt Service (MADS) is a reflection of your adjusted cash flow figure divided by debt service. The higher number reflects how many times your cash flow covers your debt service. The System's debt coverage is currently at 1.35. Last year it was 2.34 and is budged for 2.43 for FY2013. The rating service medians are approximately 3.0, which we have been steadily improving toward that goal over recent years. However, for the first quarter of this year, MADS of 1.35 has fallen significantly. Also, MADS coverage at this level would likely be a significant point of discussion in our next bond rating call in November or December.

ACTION TAKEN: Dr. Burcham moved approval of the September 2012 NRHS Financial Statement, Ms. Way seconded. The motion was approved unanimously with aye votes from, Dr. Anwar, Dr. Anderson, Mr. Clote, Dr. Burcham, Mr. McReynolds, Mr. Sherman, Ms. Way and Ms. Campbell.

Agenda Item VI. Medical Staff

A. Report from the October 10, 2012 Medical Executive Committee

Dr. Whalen reported the Medical Executive Committee met on October 10, 2012 and discussed the following:

- Approved the elimination of the Family Medicine Department due to the majority of the Active Staff members have decided to no longer admit or care for patients in the hospital. The remaining members and new members of the Family Medicine Department will be incorporated into the Medicine Department.
- The Annual General Medical Staff meeting will be held on Tuesday, November 13 at 5:30 p.m. in the Education Center. The Members–at-Large for MEC will be elected. Nominees are John Chase, MD and Lana Nelson, DO. Two additional nominees were added and they are Lesa Mulligan, MD and Nazir Balouch, MD.
- Discussed the Nurse of the Year Committee. The Nominating Committee will have the process in place so it can be awarded at the Medical Staff Holiday Social.
- The Medical Staff Holiday Social will be held at the Embassy Suites on December 6, 2012.
- Discussed the Joint Commission measures of success noting the handwriting audits for the second month were completed and show improvements of above 90%; however, Post-Op Notes took a drop to 86% for the last month. Met with the OR Committee and the Surgery Department and reformatted the Post-Op Note to the seven elements being reported on as required by Joint Commission. It has been added to the chart and should help with meeting the 90% requirement.

- Dr. Camp reported on his site visit to St. Anthony Hospital in Denver. This hospital has completely converted to CPOE and is totally paperless. The deadline for all facilities to become paperless is August 1, 2013.

B. Proposed Medical Staff Rules and Regulations Revisions Regarding Students

Dr. Whalen reported that the proposed revisions are to comply with Joint Commission and Centers for Medicare & Medicaid Services standards and regulations pertaining to authentication of student and resident progress notes.

ACTION TAKEN: Mr. Clote moved approval of the Revisions to the Medical Staff Rules and Regulations pertaining to authentication of student and resident progress notes as Recommended by the Medical Executive Committee, Dr. Burcham seconded. The motion was approved unanimously with aye votes from, Dr. Anwar, Dr. Anderson, Mr. Clote, Dr. Burcham, Ms. Way, Mr. McReynolds, Mr. Sherman, and Ms. Campbell.

C. Recommend Approval of the 2013 Patient Safety Plan

ACTION TAKEN: Mr. Clote moved approval of the of the 2013 Patient Safety Plan as Recommended by the Medical Executive Committee, Dr. Anderson seconded. The motion was approved unanimously with aye votes from, Dr. Anwar, Dr. Anderson, Mr. Clote, Dr. Burcham, Ms. Way, Mr. McReynolds, Mr. Sherman, and Ms. Campbell

Agenda Item VII. Quality and Safety Committee Report

A. Report from the October 18, 2012, Quality and Safety Committee

Ms. Campbell reported the Quality and Safety Committee met on October 18, 2012 and discussed the following:

- Reviewed the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPHS)
- Discussed the Flu Vaccination campaign.
- Talked about the Root Cause Analysis done last month.
- Reviewed the Joint Commission Measures of Success Dashboard through October 2012.
- Ms. LeAnn Richardson provided a presentation reviewing Length of Stay (LOS), Case Mix Index (CMI) and Denials and how the CMI is impacted by Excess Days, LOS, the change in the number of surgical cases, discharge days saved and lost and an increased number of long-term outlier patients.

Agenda Item VIII. Operations Committee

A. Report from the October 8, 2012, Operations Committee

Dr. Anderson reported the Operations Committee met on October 8, 2011, highlighting the following:

- Robotic surgery cases are being done by GYN and general surgery and are hindered by the limited amount of operating room block time.
- Mr. Terrell reported the Management Team attended the "Where the Healing Begins" seminar and are on-board and supportive of the program.
- Noted that the telemetry project is ongoing at the Porter campus. It will allow all telemetry patients to be monitored regardless of which floor they are placed.
- Reviewed the revised Compliance Plan
- Was provided an update on the ongoing Envigorate Healthcare Solutions project

Agenda Item IX. Finance Committee

A. Dr. Burcham reported the Finance Committee met on October 15, 2012, highlighting the following
   - Charity Care contributions for September was $788,490, with year-to-date $2,302,993.
   - Community Contributions for September was $137,839, with year-to-date $292,635.
   - Bad Debt for September was $1,038,470, with year-to-date $3,325,542.

Agenda Item X. Governance Committee Report

Ms. Campbell reported the Governance Committee met right before the Board meeting and reviewed the Board Agenda. On the City Council agenda for tomorrow night is the reappointment of three of our Board members (Tom Clote, Dr. Anderson and Dr. Anwar).

Agenda Item XI. Old Business

There was none.

Agenda Item XII. New Business

A. Recommend approval of the 2012 Compliance Plan Revisions

ACTION TAKEN: Mr. Sherman moved approval of the of the 2012 Compliance Plan revisions as presented, Dr. Anwar seconded. The motion was approved unanimously with aye votes from, Dr. Anwar, Dr. Anderson, Mr. Clote, Dr. Burcham, Ms. Way, Mr. McReynolds, Mr. Sherman, and Ms. Campbell

B. Recommend Approval of the Amendment to the NRHS Flexible Benefits Plan

ACTION TAKEN: Ms. Way moved approval of the amendment to the NRHS Flexible Benefits Plan as submitted, Dr. Anderson seconded. The motion was approved unanimously with aye votes from, Dr. Anwar, Dr. Anderson, Mr. Clote, Dr. Burcham, Ms. Way, Mr. McReynolds, Mr. Sherman, and Ms. Campbell

Agenda Item XIII Administrative Report

Mr. Whitaker provided a report on the following:

- Medical Park West, LLC, (holding company for the MPW land located at Tecumseh and consists of the System and nineteen physicians) Board voted at their October 9 meeting to grant a $500,000 cash distribution to its members. The System is a 78.2% majority owner in that project. In addition, the MPW, LLC was able to pay off all the long-term debt. We mailed checks and K1's last week to the members.
- The current flu vaccination status is at 67% as of last week. Wednesday is the last day for scheduled vaccinations, however, employees have until the end of the month to go to the Employee Health and get the vaccination. If the employee does not receive their vaccination before the end of the month, they will not be able to work until they receive the vaccination. The tabulated results will be reported to CMS in January and posted on the Hospital Compared Website in July. This report includes all employees, medical professionals (CRNAs, Advanced Nurse Practitioners, all Physicians in all categories of the Medical Staff). Employees having a medical or religious exclusion will be allowed to wear masks any time they could potentially come within 6 feet of a patient during the flu season.
- He distributed the final revision to the Strategic Goals/Initiatives for 2012-2013. The plan is to present the first Strategic Plan Report at the November Operations Committee meeting.

Ms. Melisa Herron, Mr. John Meharg, and Mr. McAdams left the meeting at 6:40 p.m.

Agenda Item XIV. Proposed Executive Session

A. Proposed Vote to Convene an Executive Session to Discuss with Legal Counsel Pending Internal Peer Review/Credentialing Investigations Regarding the Medical Staff Members/Applicants Listed Below Pursuant to 25 Okla. Stat. § 307.B. 4 and to Discuss the Annual Evaluation of the CEO

ACTION TAKEN: Dr. Burcham made a motion to adjourn into Executive Session. Dr. Anderson seconded, and the motion carried with aye votes from Dr. Anwar, Dr. Anderson, Mr. Clote, Dr. Burcham, Ms. Way, Mr. McReynolds, Mr. Sherman, Ms. Gunn and Ms. Campbell.

B. Approve or Disapprove the Medical Staff Recommendations Regarding the Physicians as Listed in XIV B (1-3) Below:

1. Recommend Medical Staff Reappointments:
   a) Shelba Bethel, MD, Active Staff – OB/Gyn Department
   b) Gautam Dehadrai, MD, Active Staff – Radiology Department
   c) Lesa Mulligan, MD, Active Staff – OB/Gyn Department
   d) Mehran Shahsavari, MD, Active Staff – Hospital Medicine Department
   e) Tadgy Stacy, MD, Active Staff – Pediatrics Department
   f) Kristin Thorp, MD, Active Staff – Medicine Department
   g) Stephen Yang, MD, Active Staff – Medicine Department
   h) Nancy Brown, MD, Active-Affiliate Staff – Medicine Department
   i) Kenneth Coffey, MD, Consulting Staff – Radiology Department
   j) Karen Swisher, MD, Consulting Staff – Medicine Department
   k) Kristen Sweet, APRN-CNP, Allied Health Staff – Cardiovascular Med. Dept.

l) Karen Tyndall, Ph.D., Allied Health Staff – Medicine Department

2. Recommend New Provisional Medical Staff Appointments
   a) Geo-Phillips Chacko, MD, Active Staff – Medicine Department
   b) Marilyn Campbell, APRN-CRNA, Allied Health Staff – Anesthesia Dept.
   c) Desiree Herring, APRN-CRNA, Allied Health Staff – Anesthesia Department

3. Recommend Appointments of Physicians in the Provisional Period:
   a) Kristin Earley, DO, Active Affiliate Staff – Family Medicine Department
   b) Mitchell Earley, DO, Active Affiliate Staff – Family Medicine Department
   c) Kelli Jones, APRN-CNP, Allied Health Staff – Pediatrics Department

C. Request to Adjourn Out of Any Such Executive Session and Return to Regular Session

ACTION TAKEN: Dr. Burcham made a motion to adjourn out of Executive Session and return to regular session. Mr. Clote seconded, and the motion passed with aye votes from Dr. Anwar, Dr. Anderson, Mr. Clote, Dr. Burcham, Ms. Way, Mr. McReynolds, Mr. Sherman, and Ms. Campbell.

Ms. Campbell noted the Board returned to regular session. There were no decisions or votes taken except to return to regular session and any information shared during the Executive Session is privileged and needs to remain in Executive Session.

D. Proposed Vote to Approve or Disapprove Medical Executive Committee Recommendations Regarding Credentialing of the Referenced Medical Staff Members as Listed in XIV B (1-3)

ACTION TAKEN: Mr. Clote made a motion to approve credentialing items as recommended by the Medical Executive Committee and Credentials Committee of all the referenced medical staff members listed in XIV B (1-3). Ms. Way seconded, and the motion was approved with aye votes from Dr. Anwar, Dr. Anderson, Mr. Clote, Dr. Burcham, Ms. Way, Mr. McReynolds, Mr. Sherman and Ms. Campbell.

Agenda Item XV. Board Open Discussion

Ms. Campbell reported the follow:

- She reminded the Board members who had not completed the Annual 2012 Compliance/HIPAA Education Program to please do so as soon as possible and send to Ms. Gonzalez.
- Since the December Board meeting is scheduled for Wednesday, December 26, 2012, the day after Christmas do we want to change the date? It was recommended that the Board change their meeting to Monday, December 17 at 5:30 pm directly following the Finance Committee.
- The June 30 financials that are presented at the July Board meeting are always a little more difficult to receive in a timely manner due to the Audit being in progress. We would like the Board to consider changing the July meeting to July 29, 2013. Mr. Hopkins is also requesting that the Finance Committee be changed to July 22, 2013. This allows the financials presented in July to have the majority of the audit's adjustments, etc.
- She presented an update on the Kaufman-Hall meetings and the ongoing meetings with City Council.

Agenda Item XVI Closing Comments

There was none.

Agenda Item XVII. Adjournment

Motion to adjourn was made by Mr. Sherman at 7:05 p.m. Dr. Anwar seconded and the motion was unanimously approved with aye votes from Mr. Clote, Dr. Anderson, Dr. Anwar, Dr. Burcham, Mr. McReynolds, Mr. Sherman, Ms. Way and Ms. Campbell.

Respectfully Submitted,

Tom Clote, Vice Chair/Secretary

Quality In Quality Out Report - Overall

Norman Regional HEALTH SYSTEM

Appropriate Care is % of patients who received all measures for which they qualified.

Data as of 11/09/12

Indicator	Goal	4th Qtr 10	1st Qtr 11	2nd Qtr 11	3rd Qtr 11	4th Qtr 11	1st Qtr 12	2nd Qtr 12	3rd Qtr 12	Jul-12	Aug-12	Sep-12
Appropriate Care-AMI	**100%**	**97%**	**97%**	**98%**	**92%**	**90%**	**96%**	**88%**	**97%**	**96%**	**96%**	**100%**
AMI-ASA on arrival	100%	98%(56/57)	100%(68/68)	100%(84/84)	100%(56/56)	99%(83/84)	100%(67/67)	99%(73/74)	99%(66/67)	100%(25/25)	96%(25/26)	100%(16/16)
AMI-ASA at discharge	100%	100%(51/51)	98%(64/65)	99%(73/74)	98%(51/52)	100%(78/78)	98%(60/61)	99%(70/71)	99%(64/65)	96%(23/24)	100%(25/25)	100%(16/16)
AMI-Beta blocker at discharge	100%	98%(50/51)	98%(64/66)	100%(69/69)	96%(49/51)	95%(69/73)	98%(59/60)	95%(62/65)	100%(65/65)	100%(25/25)	100%(24/24)	100%(16/16)
AMI-ACE inhibitor/ARB for LVSD	100%	100%(12/12)	100%(11/11)	100%(16/16)	92%(11/12)	94%(16/17)	100%(9/9)	100%(16/16)	100%(14/14)	100%(5/5)	100%(3/3)	100%(6/6)
AMI-Adult smoking cessation	**Retired 1Q 2012**	100%(21/21)	100%(17/17)	100%(25/25)	100%(24/24)	100%(35/35)						
AMI-Inpatient mortality	**Retired 1Q 2012**	2%(1/49)	3%(2/62)	3%(2/71)	2%(1/45)	1%(1/67)						
$$ AMI-Door to fibrinolysis % Within 30 minutes $$	30 min or less	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases
$$ AMI-Door to PCI *(in minutes)* % within 90 minutes $$	90 min or less as of July 1, 06	**48 mean 48 median 5 cases 100%(5/5)**	**64 mean 62 median 5 cases 100%(5/5)**	**64 mean 69 median 7 cases 100%(7/7)**	**66 mean 66 median 7 cases 100%(7/7)**	**58 mean 58 median 4 cases 100%(4/4)**	**79 mean 83 median 8 cases 100%(8/8)**	**67 mean 67 median 10 cases 100%(10/10)**	**58 mean 56 median 11 cases 100%(11/11)**	**53 mean 54 median 5 cases 100%(5/5)**	**63 mean 64 median 4 cases 100%(4/4)**	**59 mean 59 median 2 cases 100%(2/2)**
AMI-Statin at discharge **(New beginning with October 2010 discharges)**	100%	98%(49/50)	98%(61/62)	99%(66/67)	94%(47/50)	92%(65/71)	98%(53/54)	91%(60/66)	100%(59/59)	100%(21/21)	100%(24/24)	100%(14/14)
Number of cases		59 cases	71 cases	86 cases	60 cases	89 cases	75 cases	77 of 81 cases sampled	71 of 72 cases sampled	27 of 27 cases sampled	28 of 29 cases sampled	16 of 16 cases sampled
Appropriate Care-HF	**100%**	**96%**	**96%**	**95%**	**95%**	**97%**	**99%**	**97%**	**96%**	**95%**	**97%**	**96%**
HF- LVF assessment	100%	99%(99/100)	100%(71/71)	100%(76/76)	100%(74/74)	100%(77/77)	100%(74/74)	100%(78/78)	100%(82/82)	100%(22/22)	100%(33/33)	100%(27/27)
HF- ACE inhibitor/ARB for LVSD	100%	98%(42/43)	100%(31/31)	100%(33/33)	94%(33/35)	100%(36/36)	100%(19/19)	96%(27/28)	93%(26/28)	80%(4/5)	100%(13/13)	90%(9/10)
HF-Adult smoking cessation	**Retired 1Q 2012**	100%(20/20)	100%(15/15)	100%(16/16)	100%(17/17)	100%(23/23)						
$$ HF-Discharge instructions $$	100%	98%(80/82)	93%(55/59)	94%(59/63)	97%(56/58)	97%(64/66)	98%(55/56)	97%(57/59)	98%(65/66)	100%(17/17)	96%(26/27)	100%(9/9)
Number of cases		118 cases	84 of 108 cases	84 of 101 cases	84 of 105 cases	84 of 104 cases	84 of 108 cases	84 of 104 cases	84 of 97 cases	22 of 22 cases	34 of 46 cases	28 of 29 cases
Appropriate Care-Pneum	**100%**	**84%**	**97%**	**93%**	**98%**	**97%**	**100%**	**97%**	**98%**	**94%**	**100%**	**100%**
PNE-Pneumococcal screen/vaccination	**Retired 1Q 2012 (changed to global)**	100%(33/33)	100%(32/32)	100%(40/40)	100%(36/36)	100%(35/35)						
PNE-Influenza screen/vaccination *(Oct - March)*	**Retired 1Q 2012 (changed to global)**	93%(40/43)	100%(49/49)			100%(48/48)						
$$ PNE-Blood cultures prior to abx-ED $$	100%	100%(37/37)	100%(36/36)	94%(34/36)	100%(36/36)	100%(39/39)	100%(33/33)	100%(33/33)	97%(37/38)	92%(12/13)	100%(11/11)	100%(14/14)
PNE- Blood cultures prior to/after arrival to ICU	100%	100%(10/10)	100%(1/1)	83%(5/6)	100%(5/5)	100%(8/8)	100%(1/1)	100%(6/6)	100%(5/5)	100%(2/2)	100%(1/1)	100%(2/2)
PNE-Adult smoking cessation	**Retired 1Q 2012**	94%(15/16)	100%(16/16)	100%(19/19)	100%(18/18)	100%(20/20)						
PNE-Abx within 6 hours of arrival	**Retired 1Q 2012**	92%(35/38)	97%(30/31)	96%(23/24)	97%(32/33)	94%(30/32)						
$$ PNE-Abx selection-ICU/non-ICU pts $$	100%	88%(14/16)	95%(18/19)	100%(16/16)	93%(13/14)	100%(13/13)	100%(15/15)	91%(10/11)	100%(25/25)	100%(10/10)	100%(7/7)	100%(8/8)
PNE-Abx selection for non-ICU pts	100%	87%(13/15)	94%(17/18)	100%(15/15)	92%(12/13)	100%(13/13)	100%(14/14)	91%(10/11)	100%(22/22)	100%(8/8)	100%(7/7)	100%(7/7)
PNE-Abx selection for ICU pts	100%	100%(1/1)	100%(1/1)	100%(1/1)	100%(1/1)	No qualifying cases	100%(1/1)	No qualifying cases	100%(3/3)	100%(2/2)	No qualifying cases	100%(1/1)
PNE-Door to abx time *(in minutes)*	240 min or less **Retired 1Q 2012**	165 mean 145 median	156 mean 142 median	168 mean 154 median	155 mean 127 median	165 mean 127 median						
Number of cases		66 of 214 cases	68 of 298 cases	66 of 187 cases	66 of 147 cases	66 of 176 cases	69 of 274 cases	66 of 180 cases	69 of 143 cases	25 of 53 cases	22 of 40 cases	22 of 49 cases
Core Immunization	**Goal**	**4th Qtr 10**	**1st Qtr 11**	**2nd Qtr 11**	**3rd Qtr 11**	**4th Qtr 11**	**1st Qtr 12**	**2nd Qtr 12**	**3rd Qtr 12**	**Jul-12**	**Aug-12**	**Sep-12**
Pneumococcal Immunization	100%						99% (212/213)	98% (138/141)	98% (135/137)	100% (41/41)	98% (42/43)	98% (52/53)
Influenza Immunization	100%						97% (350/360)					
Number of cases							366 of 4875 cases	332 of 4602 cases	331 of 4687 cases	117 of 1537 cases	107 of 1676 cases	107 of 1475

AMI:Acute Myocardial Infarction HF:Heart Failure PNE:Pneumonia

$$ = ***VBP Clinical Process of Care Measures***

SURGICAL CARE IMPROVEMENT PROJECT - OVERALL

Norman Regional HEALTH SYSTEM

Appropriate Care is % of patients who received all measures for which they qualified.

DATA AS OF 11/09/2012

Below 80% = Red		80 - 89% = Yellow								90 - 100% = Green		
Indicator	Goal	4th Q 10	1st Q 11	2nd Q 11	3rd Q 11	4th Q 11	1st Q 12	2nd Q 12	3rd Q 12	Jul-12	Aug-12	Sep-12
Appropriate Care (ABX Measures Only)	95%	88% (82/93)	93% (86/92)	94% (91/97)	95% (94/99)	93% (86/92)	96% (85/89)	93% (94/101)	96% (101/105)	100% (30/30)	95% (37/39)	94% (34/36)
Infection All or None bundle (All Infection Measures)	95%	81% (110/136)	84% (112/133)	88% (119/136)	88% (128/146)	90% (125/139)	92% (123/133)	93% (131/141)	93% (139/149)	96% (44/46)	95% (53/56)	89% (42/47)
Appropriate Care (All SCIP Measures)	95%	79% (108/136)	81% (108/133)	86% (117/136)	84% (123/146)	87% (121/139)	91% (121/133)	87% (122/141)	90% (134/149)	91% (42/46)	91% (51/56)	87% (41/47)
$$ INF 1-Prophylactic Abx within 1 hr(2 hr for vanc & quinolones) $$	95%	98% (90/92)	98% (87/89)	98% (93/95	97% (96/99)	99% (90/91)	98% (87/89)	97% (98/101)	99% (104/105)	100% (30/30)	100% (39/39)	97% (35/36)
$$ INF 2-Appropriate Prophylactic Abx selection $$	95%	98% (91/93)	100% (91/91)	100% (96/96)	98% (97/99)	100% (92/92)	100% (87/87)	100% (101/101)	99% (104/105)	100% (30/30)	97% (38/39)	100% (36/36)
$$ INF 3-Prophylactic Abx DC within 24 hrs (48hrs Cardiac) $$	95%	92% (82/89)	95% (80/84)	96% (87/91)	99% (95/96)	94% (77/82)	98% (80/82)	96% (96/100)	97% (98/101)	100% (28/28)	97% (38/39)	94% (32/34)
$$ INF 4-CABG/Other Card Surg 6 AM postop glucose less than 200 mg/dL postop days 1 & 2 $$	100%	91% (10/11)	86% (12/14)	100% (15/15)	94% (15/16)	83% (10/12)	94% (16/17)	94% (15/16)	88% (15/17)	100% (6/6)	100% (4/4)	71% (5/7)
INF 6-Appropriate Hair Removal Documented	100%	100% (131/131)	100% (128/128)	100% (131/131)	100% (141/141)	100% (137/137)	100% (133/133)	100% (140/140)	100% (149/149)	100% (46/46)	100% (56/56)	100% (47/47)
INF 9-Urinary catheter removed on POD 1 or POD 2	95%	79% (57/72)	80% (57/71)	83% (54/65)	85% (63/74)	90% (55/61)	93% (66/71)	95% (62/65)	95% (72/76)	93% (26/28)	96% (24/25)	96% (22/23)
INF 10-Surgery patients with perioperative temperature management	95%	100% (121/121)	100% (117/117)	100% (115/115)	98% (123/125)	100% (124/124)	100% (111/111)	100% (123/123)	100% (127/127)	100% (38/38)	100% (51/51)	100% (38/38)
Indicator	Goal	4th Q 10	1st Q 11	2nd Q 11	3rd Q 11	4th Q 11	1st Q 12	2nd Q 12	3rd Q 12	Jul-12	Aug-12	Sep-12
$$ Card 3-Beta blocker received perioperatively (if previously on a beta blocker) $$	95%	91% (20/22)	90% (18/20)	100% (17/17)	93% (28/30)	93% (26/28)	96% (24/25)	89% (31/35)	92% (49/53)	94% (15/16)	87% (13/15)	95% (21/22)
$$ VTE 1-Appropriate VTE prophylaxis ordered $$	95%	100% (38/38)	100% (53/53)	99% (91/92)	97% (91/94)	99% (103/104)	99% (100/101)	97% (103/106)	99% (104/105)	100% (31/31)	98% (40/41)	100% (33/33)
$$ VTE 2-Appropriate VTE prophylaxis received within 24 hrs prior to surgery to 24 hours after surgery $$	95%	97% (37/38)	96% (51/53)	91% (90/91	97% (91/94)	99% (102/103)	99% (99/100)	94% (100/106)	97% (101/104)	97% (30/31)	98% (39/40)	97% (32/33)
Number of cases		138 of 389 cases sampled	137 of 326 cases sampled	139 of 316 cases sampled	151 of 355 cases sampled	139 of 334 cases sampled	136 of 285 cases sampled	144 of 289 cases sampled	151 of 296 cases sampled	47 of 107 cases sampled	57 of 108 cases sampled	47 of 81 cases sampled

Cases are sampled beginning with 4th Q 2009

$$ = VBP Clinical Process of Care Measures

Norman Regional HEALTH SYSTEM

HOSPITAL OUTPATIENT SURGERY REPORT OVERALL

DATA AS OF 11/09/12

Below 80% = Red		80 - 89% = Yellow								90 - 100% = Green		
Indicator	**Goal**	***4th Qtr 10***	***1st Qtr 11***	***2nd Qtr 11***	***3rd Qtr 11***	***4th Qtr 11***	***1st Qtr 12***	***2nd Qtr 12***	***3rd Qtr 12***	***Jul-12***	***Aug-12***	***Sep-12***
OP-6-Prophylactic Abx within 1 hr(2 hr for vanc & quinolones)	**95%**	**96% (135/141)**	**98% (122/124)**	**100% (142/142)**	**100% (138/138)**	**99% (165/167)**	**99% (142/144)**	**99% (153/154)**	**99% (149/151)**	**100% (55/55)**	**98% (49/50)**	**98% (45/46)**
OP-7-Appropriate Prophylactic Abx selection	**95%**	**99% (134/135)**	**100% (123/123)**	**100% (141/141)**	**99% (136/138)**	**98% (162/166)**	**100% (143/143)**	**99% (153/154)**	**98% (148/151)**	**98% (54/55)**	**98% (49/50)**	**98% (45/46)**
Number of cases		145 of 191 cases	125 of 154 cases	150 of 208 cases	142 of 180 cases	171 of 254 cases	146 of 202 cases	155 of 220 cases	152 of 220 cases	56 of 86 cases	50 of 73 cases	46 of 61 cases

Cases sampled beginnig with 4th Qtr 2010

Norman Regional HEALTH SYSTEM

HOSPITAL OUTPATIENT EMERGENCY DEPARTMENT MEASURES

DATA AS OF 11/09/12

Below 80% = Red		80 - 89% = Yellow								90 - 100% = Green		
Indicator-Outpt AMI/CP	**Goal**	***4th Qtr 10***	***1st Qtr 11***	***2nd Qtr 11***	***3rd Qtr 11***	***4th Qtr 11***	***1st Qtr 12***	***2nd Qtr 12***	***3rd Qtr 12***	***Jul-12***	***Aug-12***	***Sep-12***
OP-4a-AMI/Chest Pain-ASA at Arrival	**95%**	**100% (1/1)**	**100% (8/8)**	**100% (6/6)**	**100% (2/2)**	**100% (2/2)**	0 cases	**100% (2/2)**	**100% (3/3)**	**100% (3/3)**	0 cases	0 cases
OP-4b-AMI ASA at arrival	**95%**	0 cases	0 cases	**100% (1/1)**	0 cases	**100% (1/1)**	0 cases	**100% (1/1)**	**100% (1/1)**	**100% (1/1)**	0 cases	0 cases
OP-4c-Chest Pain ASA at arrival	**95%**	**100% (1/1)**	**100% (8/8)**	**100% (5/5)**	**100% (2/2)**	**100% (1/1)**	0 cases	**100% (1/1)**	**100% (2/2)**	**100% (2/2)**	0 cases	0 cases
OP-1-Mean Time to Fibrinolysis	**30 minutes or less**	0 cases	No qualifying cases	No qualifying cases	0 cases	0 cases	0 cases	No qualifying cases	No qualifying cases	No qualifying cases	0 cases	0 cases
OP-2-AMI-Door to Fibrinolysis % Within 30 minutes	**30 minutes or less**	0 cases	No qualifying cases	No qualifying cases	0 cases	0 cases	0 cases	No qualifying cases	No qualifying cases	No qualifying cases	0 cases	0 cases
OP-3b-Mean time to Transfer to Another Facility for Acute Coronary Intervention	**90 minutes or less**	0 cases	No qualifying cases	**224 mean 1 case**	0 cases	0 cases	0 cases	No qualifying cases	No qualifying cases	No qualifying cases	0 cases	0 cases
OP-3c-Mean Time to Transfer w/Reason for No Fibrinolytics	**Door to balloon time 90 minutes or less**	0 cases	No qualifying cases	No qualifying cases	0 cases	0 cases	0 cases	No qualifying cases	No qualifying cases	No qualifying cases	0 cases	0 cases
OP-5a-Mean Time to ECG - Overall	**Target within 10 minutes of arrival**	**0 mean 1 cases**	**8 mean 8 cases**	**17 mean 6 cases**	**9 mean 2 cases**	**17 mean 2 cases**	0 cases	**11 mean 2 cases**	**5 mean 3 cases**	**5 mean 3 cases**	0 cases	0 cases
OP-5b-AMI Mean Time to ECG	**within 10 minutes**	0 cases	0 cases	**33 mean 1 case**	0 cases	**11 mean 1 case**	0 cases	**16 mean 1 case**	**0 mean 1 cases**	**0 mean 1 cases**	0 cases	0 cases
OP-5c-Chest Pain Mean Time to ECG	**within 10 minutes**	**0 mean 1 case**	**8 mean 8 cases**	**13 mean 5 cases**	**9 mean 2 cases**	**23 mean 1 case**	0 cases	**5 mean 1 case**	**7 mean 2 cases**	**7 mean 2 cases**	0 cases	0 cases
Number of cases		1 case	8 cases	6 cases	2 cases	2 cases	0 cases	2 cases	3 cases	3 cases	0 cases	0 cases
Below 80% = Red		**80 - 89% = Yellow**								**90 - 100% = Green**		
Indicator-Outpt ED Throughput	**Goal**	***4th Qtr 10***	***1st Qtr 11***	***2nd Qtr 11***	***3rd Qtr 11***	***4th Qtr 11***	***1st Qtr 12***	***2nd Qtr 12***	***3rd Qtr 12***	***Jul-12***	***Aug-12***	***Sep-12***
OP-18b- Mean Time ED arrival to ED Departure	**MEDIAN = 140 minutes Nat'l MEDIAN =112 minutes State**						**81 median 385 cases**	**84 median 390 cases**	**77 median 97 cases**	**81 median 34 cases**	**65 median 32 cases**	**96 median 31 cases**
OP-20- Mean Time Door to Provider Evaluation	**MEDIAN = 30 minutes Nat'l MEDIAN = 27 minutes State**						**15 median 200 cases**	**12 median 269 cases**	**13 median 56 cases**	**10 median 18 cases**	**12 median 19 cases**	**17 median 19 cases**
Number of cases							396 of 25246 cases	409 of 24891 cases	105 of 24375 cases	34 of 7989 cases	37 of 8206 cases	34 of 8179 cases
Indicator-HOP Pain Management	**Goal**	***4th Qtr 10***	***1st Qtr 11***	***2nd Qtr 11***	***3rd Qtr 11***	***4th Qtr 11***	***1st Qtr 12***	***2nd Qtr 12***	***3rd Qtr 12***	***Jul-12***	***Aug-12***	***Sep-12***
OP-21- Mean Time to Pain Management in Long Bone Fracture	**MEDIAN = 62 minutes Nat'l MEDIAN = 59 minutes State**						**47 median 76 cases**	**41 median 80 cases**	**38 median 69 cases**	**37 median 24 cases**	**42 median 27 cases**	**39 median 18 cases**
Number of cases							139 of 176 cases	157 of 215 cases	140 of 179 cases	41 of 50 cases	52 of 68 cases	47 of 61 cases
Indicator-Outpt Stroke	**Goal**	***4th Qtr 10***	***1st Qtr 11***	***2nd Qtr 11***	***3rd Qtr 11***	***4th Qtr 11***	***1st Qtr 12***	***2nd Qtr 12***	***3rd Qtr 12***	***Jul-12***	***Aug-12***	***Sep-12***
OP-23- Head CT/MRI results for STK Patient available w/in 45 minutes	**100%**						**75% (3/4)**	**100% (1/1)**	**100% (3/3)**	No qualifying cases	**100% (1/1)**	**100% (2/2)**
Number of cases							7 cases	11 cases	15 cases	3 cases	7 cases	5 cases

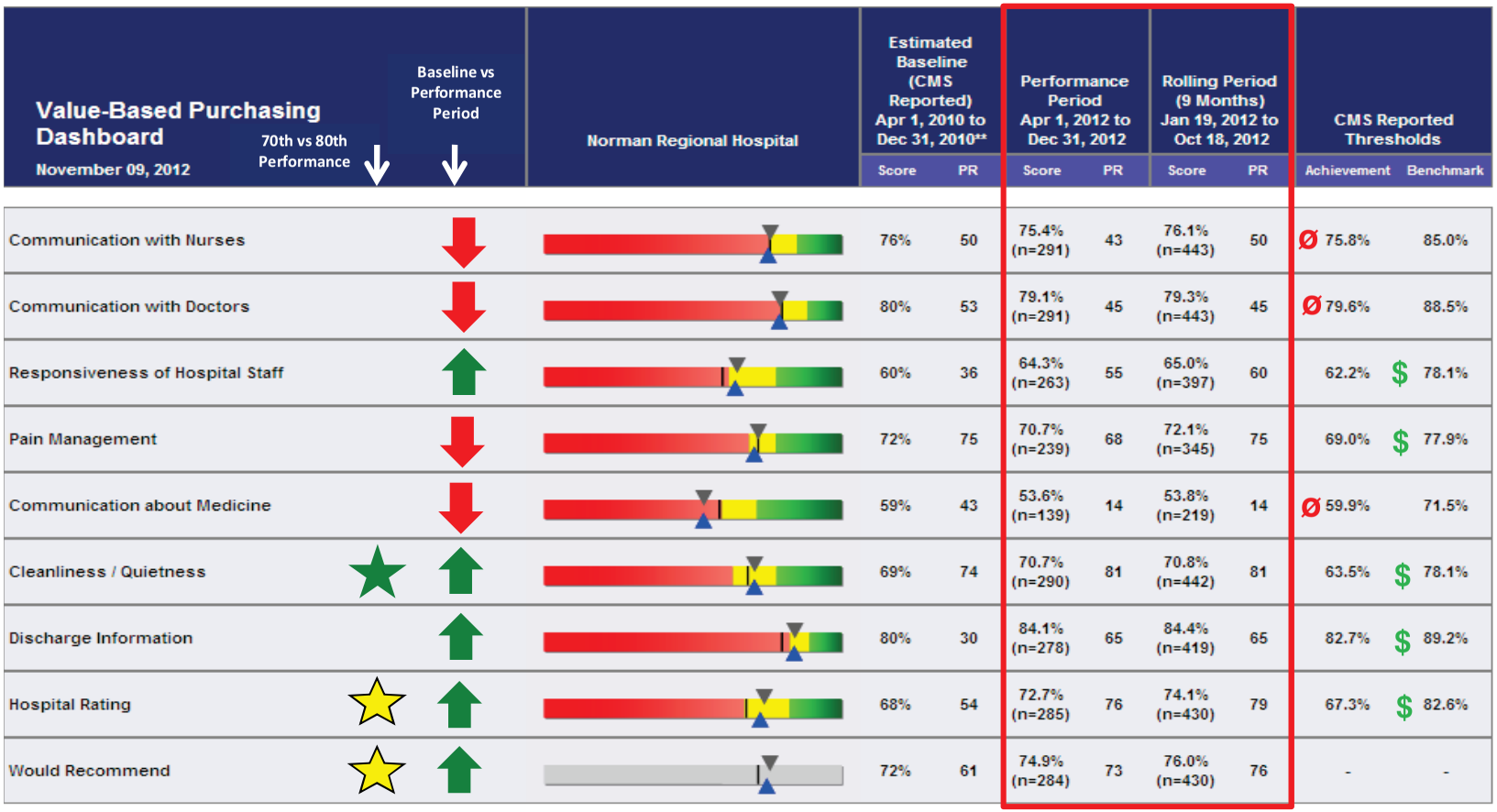
Norman Regional HEALTH SYSTEM

HOSPITAL INPATIENT EMERGENCY DEPARTMENT MEASURES

DATA AS OF 11/09/12

Below 80% = Red		80 - 89% = Yellow								90 - 100% = Green		
Indicator - Inpt AMI	**Goal**	**4th Qtr 10**	**1st Qtr 11**	**2nd Qtr 11**	**3rd Qtr 11**	**4th Qtr 11**	**1st Qtr 12**	**2nd Qtr 12**	**3rd Qtr 12**	**Jul-12**	**Aug-12**	**Sep-12**
AMI-1- Aspirin at Arrival	**100%**	**98%(56/57)**	**100%(68/68)**	**100%(84/84)**	**100%(56/56)**	**99%(80/81)**	**100%(64/64)**	**99%(73/74)**	**99%(66/67)**	**100%(25/25)**	**96%(25/26)**	**100%(16/16)**
$$ AMI-Door to fibrinolysis % Within 30 minutes $$	30 min or less	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases	No qualifying cases
$$ AMI-Door to PCI *(in minutes)* % within 90 minutes $$	90 min or less as of July 1, 06	**48 mean 48 median 5 cases 100%(5/5)**	**64 mean 62 median 5 cases 100%(5/5)**	**64 mean 69 median 7 cases 100%(7/7)**	**66 mean 66 median 7 cases 100%(7/7)**	**63 mean 64 median 3 cases 100%(3/3)**	**79 mean 83 median 8 cases 100%(8/8)**	**67 mean 67 median 10 cases 100%(10/10)**	**58 mean 56 median 11 cases 100%(11/11)**	**53 mean 54 median 5 cases 100%(5/5)**	**63 mean 64 median 4 cases 100%(4/4)**	**59 mean 59 median 2 cases 100%(2/2)**
Number of cases		59 cases	71 cases	86 cases	60 cases	86 cases	72 cases	79 of 83 cases sampled	71 of 72 cases sampled	27 of 27 cases sampled	28 of 29 cases sampled	16 of 16 cases sampled
Indicator - Inpt Pneumonia	**Goal**	**4th Qtr 10**	**1st Qtr 11**	**2nd Qtr 11**	**3rd Qtr 11**	**4th Qtr 11**	**1st Qtr 12**	**2nd Qtr 12**	**3rd Qtr 12**	**Jul-12**	**Aug-12**	**Sep-12**
$$ PNE-Blood cultures prior to abx-ED $$	100%	**100%(37/37)**	**100%(36/36)**	**94%(34/36)**	**100%(36/36)**	**100%(39/39)**	**100%(33/33)**	**100%(33/33)**	**97%(37/38)**	**92%(12/13)**	**100%(11/11)**	**100%(14/14)**
PNE- Blood cultures prior to/after arrival to ICU	100%	**100%(3/3)**	**100%(10/10)**	**100%(1/1)**	**83%(5/6)**	**100%(5/5)**	**100%(1/1)**	**100%(6/6)**	**100%(5/5)**	**100%(2/2)**	**100%(1/1)**	**100%(2/2)**
PNE-Abx within 6 hours of arrival	**Retired 1Q 2012**	**92%(35/38)**	**97%(30/31)**	**96%(23/24)**	**97%(32/33)**	**94%(30/32)**						
$$ PNE-Abx selection-ICU/non-ICU pts $$	100%	**88%(14/16)**	**95%(18/19)**	**100%(16/16)**	**93%(13/14)**	**100%(13/13)**	**100%(15/15)**	**92%(11/12)**	**100%(25/25)**	**100%(10/10)**	**100%(7/7)**	**100%(8/8)**
PNE-Abx selection for non-ICU pts	100%	**87%(13/15)**	**94%(17/18)**	**100%(15/15)**	**92%(12/13)**	**100%(13/13)**	**100%(14/14)**	**91%(10/11)**	**100%(22/22)**	**100%(8/8)**	**100%(7/7)**	**100%(7/7)**
PNE-Abx selection for ICU pts	100%	**100%(1/1)**	**100%(1/1)**	**100%(1/1)**	**100%(1/1)**	No qualifying cases	**100%(1/1)**	**100%(1/1)**	**100%(3/3)**	**100%(2/2)**	**No qualifying cases**	**100%(1/1)**
PNE-Door to abx time *(in minutes)*	**Retired 1Q 2012**	165 mean 145 median	156 mean 142 median	168 mean 154 median	155 mean 127 median	165 mean 127 median						
Number of cases		66 of 214 cases	68 of 298 cases	66 of 187 cases	66 of 147 cases	66 of 176 cases	69 of 274 cases	66 of 180 cases	69 of 143 cases	25 of 53 cases	22 of 40 cases	22 of 49 cases
Indicator - Inpt ED Throughput	**Goal**	**4th Qtr 10**	**1st Qtr 11**	**2nd Qtr 11**	**3rd Qtr 11**	**4th Qtr 11**	**1st Qtr 12**	**2nd Qtr 12**	**3rd Qtr 12**	**Jul-12**	**Aug-12**	**Sep-12**
ED-1a- Median Time ED arrival to ED Departure	**277 minutes is Nat'l Average**						**238 median 218 cases**	**256 median 150 cases**	**266 median 116 cases**	**261 median 35 cases**	**248 median 34 cases**	**275 median 47 cases**
ED-2-a- Admit Decision Time to ED Departure Time	**98 minutes is Nat'l Average**						**125 median 172 cases**	**127 median 116 cases**	**116 median 91 cases**	**100 median 28 cases**	**110 median 27 cases**	**149 median 36 cases**
Number of cases							365 of 4876 cases	330 of 4599 cases	331 of 4687 cases	117 of 1537 cases	107 of 1675 cases	107 of 1475 cases

NRCPicker



Norman Regional
HEALTH SYSTEM

DAILY FLU STATISTICS - NOVEMBER 8, 2012

TOTAL EMPLOYEES IMMUNIZED/DECLINING	**2712**	**99.12%**
TOTAL EMPLOYEES IMMUNIZED	**2672**	**97.66%**
Employees Immunized	2400	
Employees Immunized - other location	272	
Active Employees at this date	2736	
TOTAL EMPLOYEES DECLINING FLU VAC (Due to allergies, religion, or physician orders)	40	

TOTAL ACTIVE PHYSICIANS & ALLIED HEALTH PROVIDERS		**67.40%**
TOTAL ACTIVE PHYSICIANS & ALLIED HEALTH PROVIDERS IMMUNIZED/DECLINATION	215	
TOTAL ACTIVE PHYSICIANS & ALLIED HEALTH PROVIDERS	319	

TOTAL CONTRACTOR/ANCILLIARY IMMUNIZATIONS/DECLINATION	**71**	**60.17%**
Total Contractors/Ancilliary at this Date	118	

TOTAL MMC/HPX/PORTER VOLUNTEERS IMMUNIZATIONS/DECLINATIONS	**373**	**96.38%**
Total Volunteers at this Date	387	

OTHERS IMMUNIZED (Board Members)	**12**	**N/A**

FINANCIAL STATEMENT SUMMARY
October 2012

I. Financial Position

Cash and cash equivalents at the end of October were $49.8 M compared to $42.7 M in the prior month. The increase in cash and cash equivalents of $7.0 M was due primarily to the higher patient collections and the SHOPP receipt of $3.3M. The higher collections in October stemmed from there being 23 business days during the month and a $1.5M overpayment received from Medicaid. This overpayment was a mistake made by the State Medicaid program and was paid back to the State in November. Collections in October were $33.9M, and for the past twelve months the average monthly collections were $28.7M. Disbursements in September were $26.8M, and for the past twelve months the average monthly disbursements were $27.1.

Investments at the end of October were $58.9 M, compared to $59.4 M in the prior month. The decrease of $0.4 M was due to the net of realized and unrealized market gains of $0.4M.

Net accounts receivable at the end of October were $43.4 M, a decrease of $2.0 M or 4.4% from the prior month.

Other receivables at the end of October were $7.2M, compared to $4.1M in the prior month. The increase of $3.1M was due primarily to the accrual of Medicare and Medicaid Meaningful Use revenue totaling $2.8M.

Total current assets at the end of October were $175.5 M compared to $166.5 M the prior month. The increase in current assets was due primarily to the changes in cash, investments, accounts receivable, and other receivables.

Total current liabilities at the end of October were $48.1 M compared to $41.7 M the prior month. The increase in current liabilities of $6.5 was primarily due to the deferred revenue from the SHOPP program of $2.2M, the overpayment received from Medicaid of $1.5M recorded in accounts payable, and an increase in accrued payroll of $1.1M. The increase in accrued payroll was primarily due to the change in accrual period from September to October.

FINANCIAL STATEMENT SUMMARY
October 2012

II. Financial Results

For October net revenue was $31.1 M compared to a budget of $32.1 M (3.0% unfavorable). October net revenue was $1.0 M unfavorable to budget. October net revenue was under budget partially due to lower inpatient surgical volume. Inpatient surgical cases were 87 under budget. Adjusted discharges in October were 3,039 compared to a budget of 3,203 (5.1% unfavorable). Denials and government audit adjustments were other important factors that reduced net revenue in October.

Operating expenses for October were $28.4 M compared to the $28.5 M budget (0.1% favorable). When viewed on a per-adjusted-discharge basis, operating expense for the month was $1.4 M unfavorable to budget (unfavorable variance in operating expenses per-adjusted-discharge of $465.66 times actual adjusted discharges of 3,039).

Year-to-date net revenue was $109.5 M compared to a budget of $117.8 M (7.0% unfavorable). Year-to-date net revenue was $8.3 M unfavorable to budget. Fiscal year-to-date adjusted discharges were 12,202 compared to a budget of 12,713 (4.0% unfavorable). Other important factors that have reduced the year-to-date net revenue were governmental audit adjustments and a lower system case mix.

Year-to-date operating expenses were $109.6 M compared to the $112.7 M budget (2.8% favorable). Operating expenses were $3.1 M favorable to budget. When viewed on a per adjusted-discharge-basis, year-to-date operating expense was $1.40 M unfavorable to budget (unfavorable variance in operating expenses per-adjusted-discharge of $114.44 times actual adjusted discharges of 12,202).

FINANCIAL STATEMENT SUMMARY
October 2012

III. Statistical Summary

Norman Regional Hospital

October discharges for NRH were 826 compared to a budget of 873 (5.4% unfavorable). The results were primarily driven by acute discharges being under budget by 50 cases (6.5% unfavorable). Rehab discharges were 1 under budget (2.5% unfavorable) and Behavioral Medicine discharges were 4 above budget (6.1% favorable). The October acute average length of stay was 4.9 days compared to a budget of 4.4 days. The acute average length of stay in October increased from the September acute average length of stay of 4.2 days.

Year-to-date discharges for NRH were 3,309 compared to a budget of 3,465 (4.5% unfavorable). The results were primarily driven by acute discharges being under budget by 184 cases (6.0% unfavorable). Rehab discharges were 9 under budget (5.7% unfavorable) and Behavioral Medicine discharges were 37 above budget (14.1% favorable).

Hospital outpatient registrations for October were 14,394 compared to a budget of 14,161 (1.6% favorable).

Year-to-date hospital outpatient registrations were 55,006 compared to a budget of 56,187 (2.1% unfavorable).

Moore Medical Center

October discharges for MMC were 125 compared to a budget of 132 (5.3% unfavorable). The October acute average length of stay was 2.6 days compared to a budget of 2.4 days. The acute average length of stay in October was unchanged from the September acute average length of stay of 2.6 days.

Year-to-date discharges were 472 compared to a budget of 524 (9.9% unfavorable).

Hospital outpatient registrations for October were 5,134 compared to a budget of 5,349 (4.0% unfavorable).

Year-to-date hospital outpatient registrations were 19,546 compared to a budget of 21,223 (7.9% unfavorable).

HealthPlex Hospital

October discharges for the HealthPlex Hospital were 477 compared to a budget of 505 (5.5% unfavorable). The October acute average length of stay was 3.0 days compared to a budget of 3.0 days. The acute average length of stay in October was unchanged from the September average length of stay of 3.0 days.

Year-to-date discharges for the HealthPlex Hospital were 1,952 compared to a budget of 2,004 (2.6% unfavorable).

Hospital outpatient registrations for October were 3,778 compared to a budget of 3,708 (1.9% favorable).

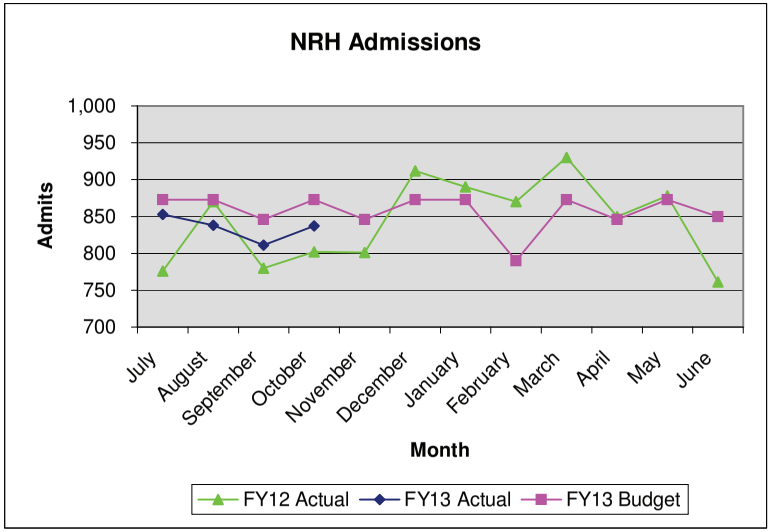
Year-to-date hospital outpatient registrations were 14,551 compared to a budget of 14,712 (1.1% unfavorable).

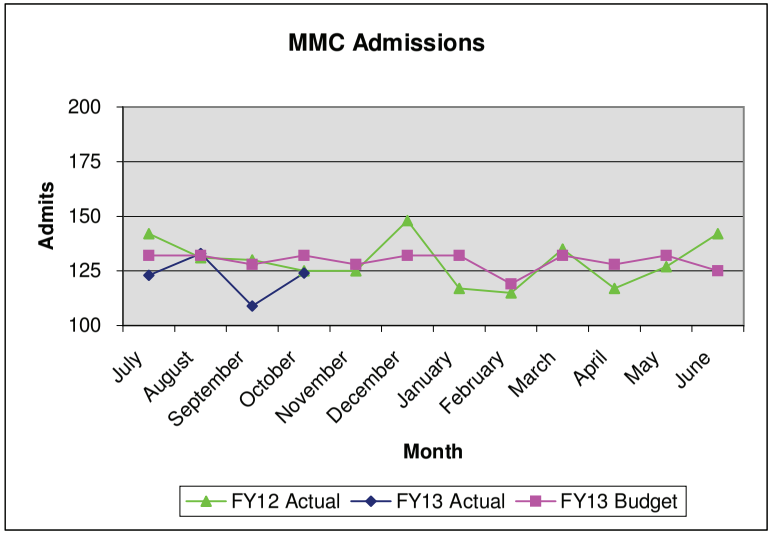
Clinics

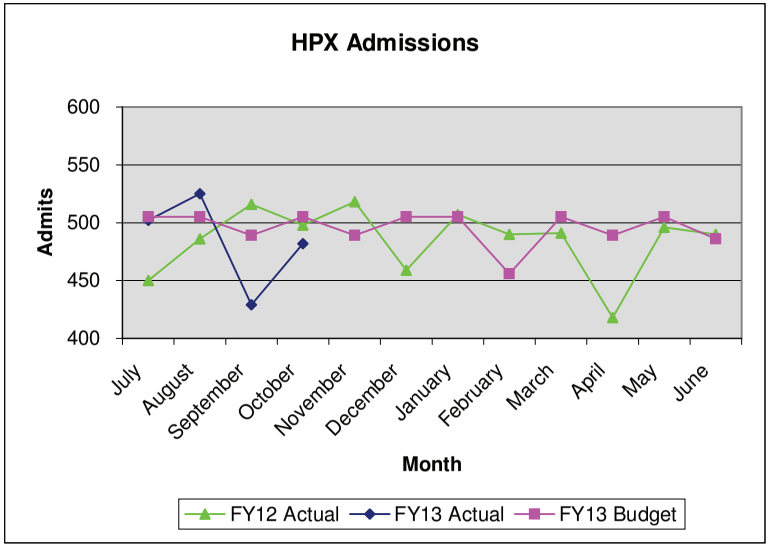
Clinic registrations for October were 12,681 compared to a budget of 16,859 (24.8% unfavorable). October clinic registrations were 4,178 under budget. Clinics with significant variances to budget were: Norman Heart and Vascular (173 under budget), Endocrinologist (157 under budget), Central OK OB/GYN (706 under budget), Pediatrics (204 under budget), MMC Family Medicine North (380 under budget), HPX Family Medicine (469 under budget), Family Medicine Lindsay (1,000 under budget), Family Medicine Findley (282 under budget), and Pulmonary Clinic Robinson Medical Plaza (156 under budget).

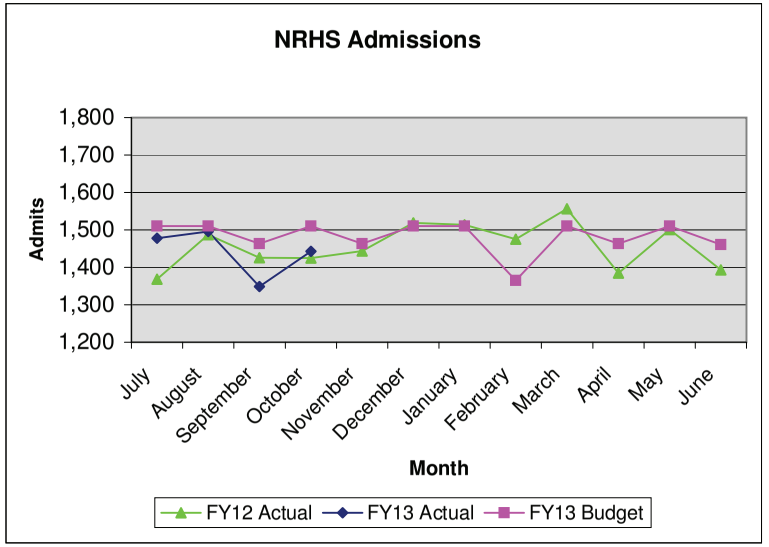
Year-to-date registrations were 52,180 compared to a budget of 61,283 (14.9% unfavorable). Year to date clinic registrations were 9,103 under budget.

NRHS
Admissions

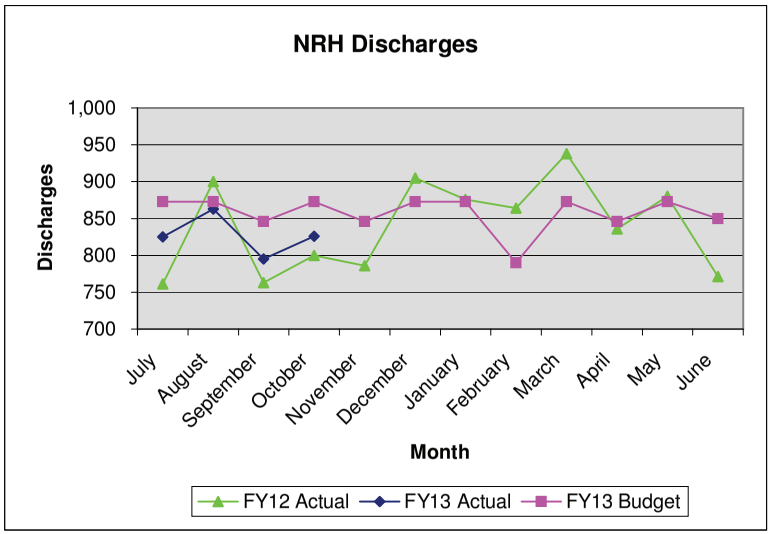


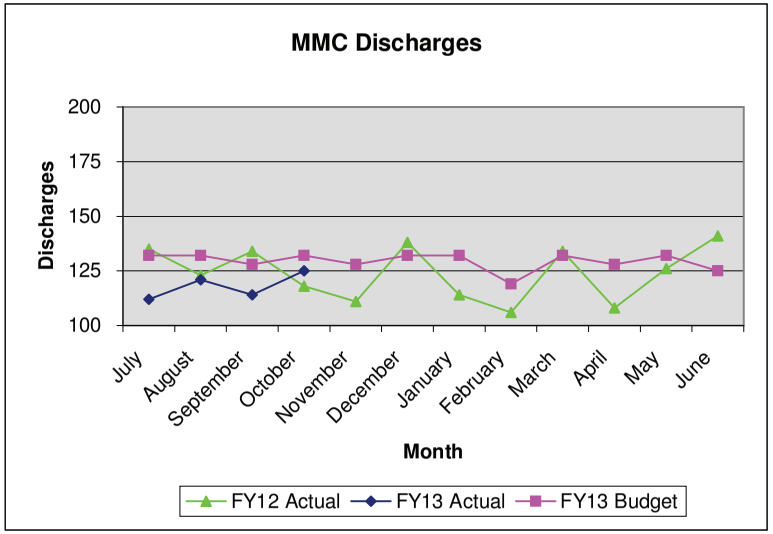


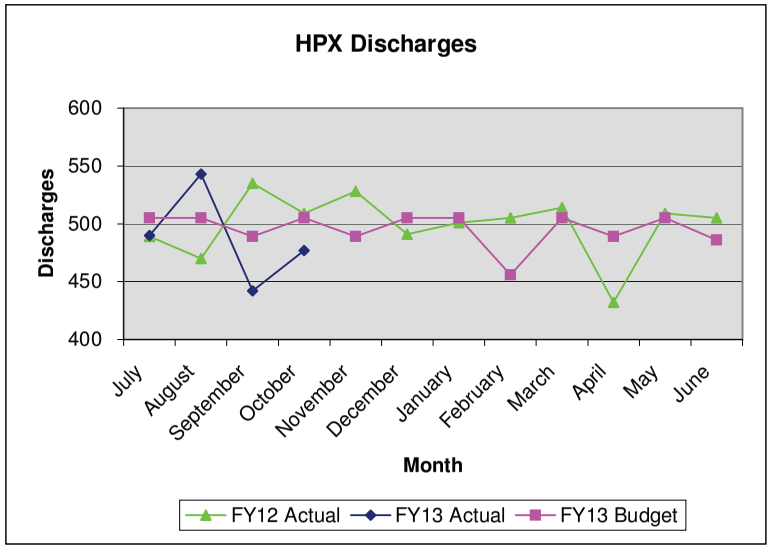


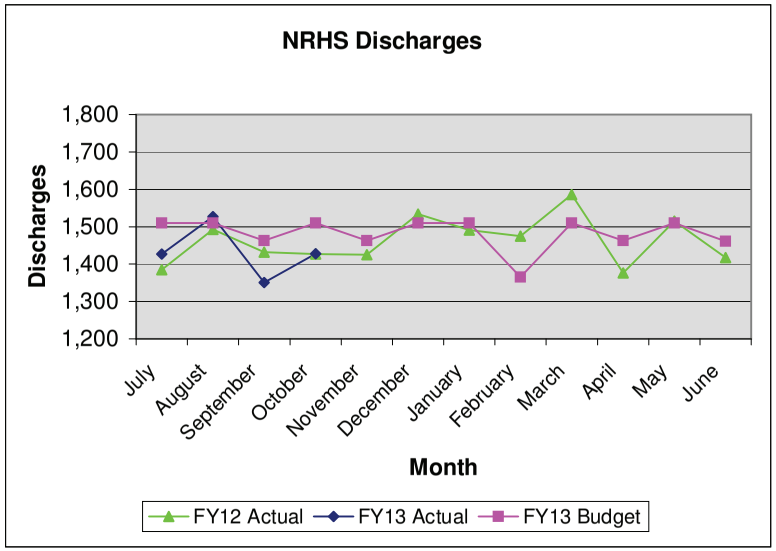


NRHS
Discharges

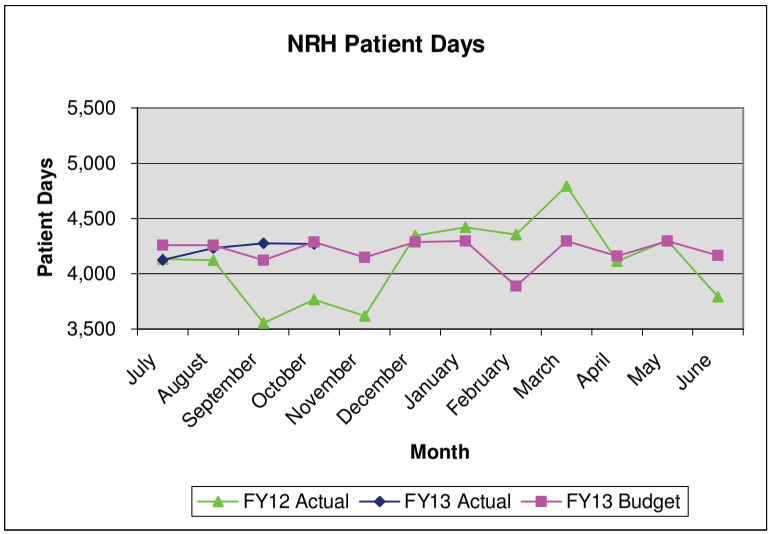


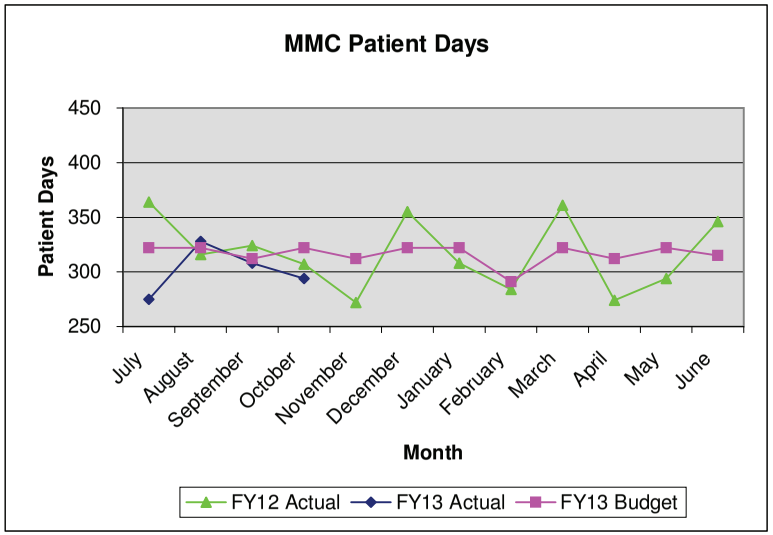


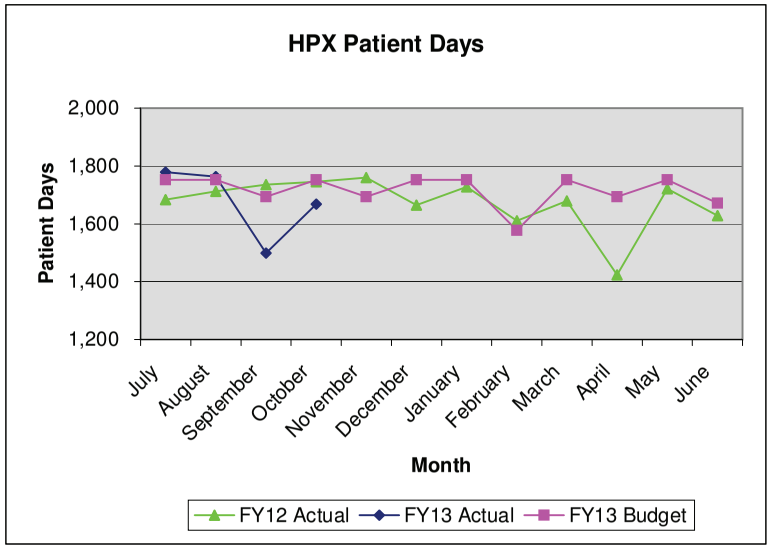


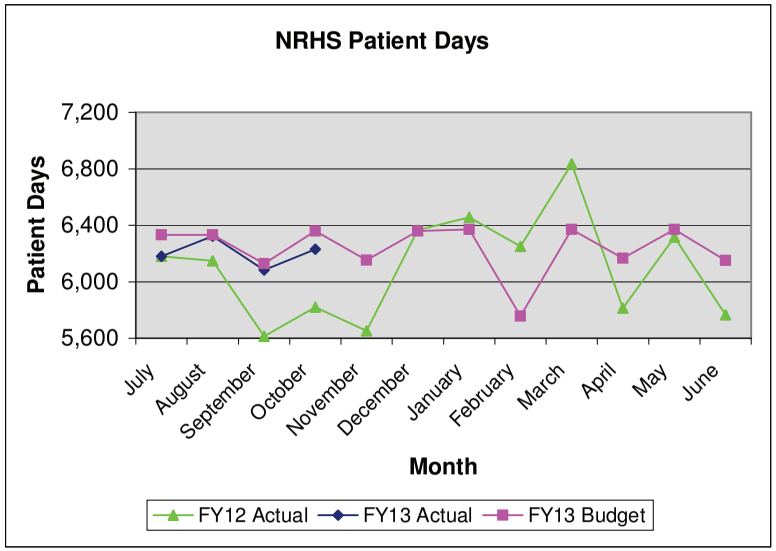


NRHS
Patient Days

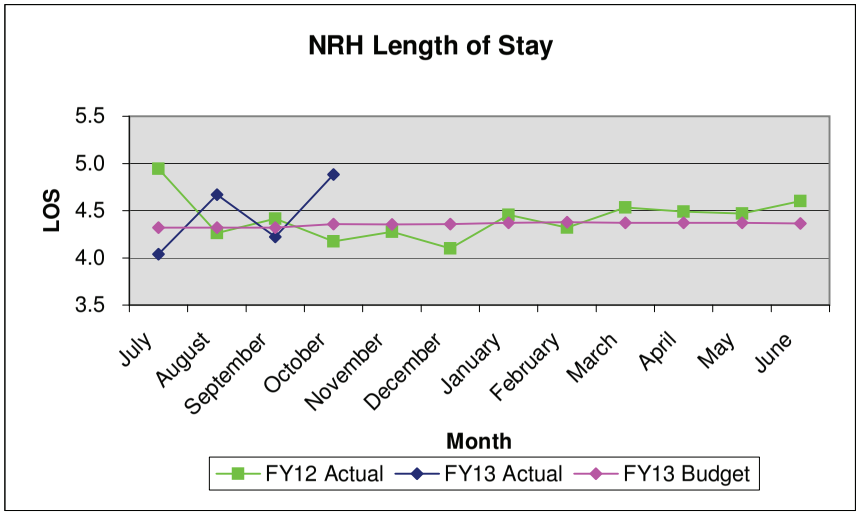


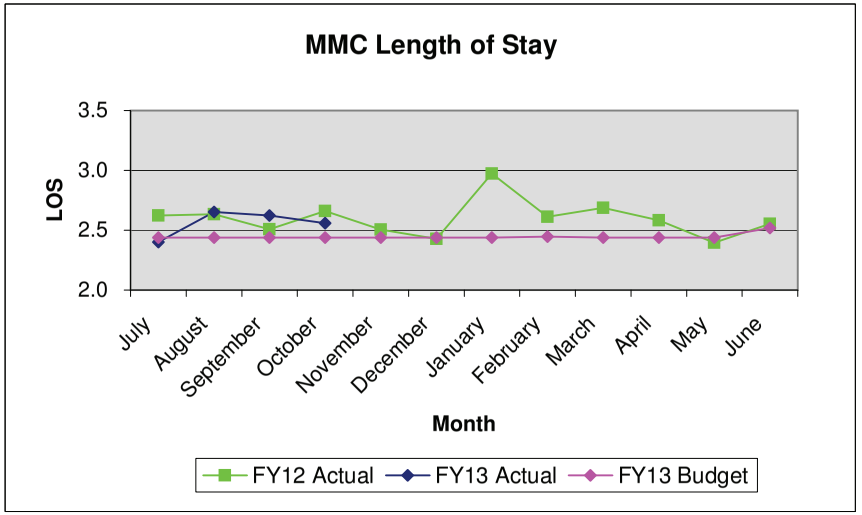


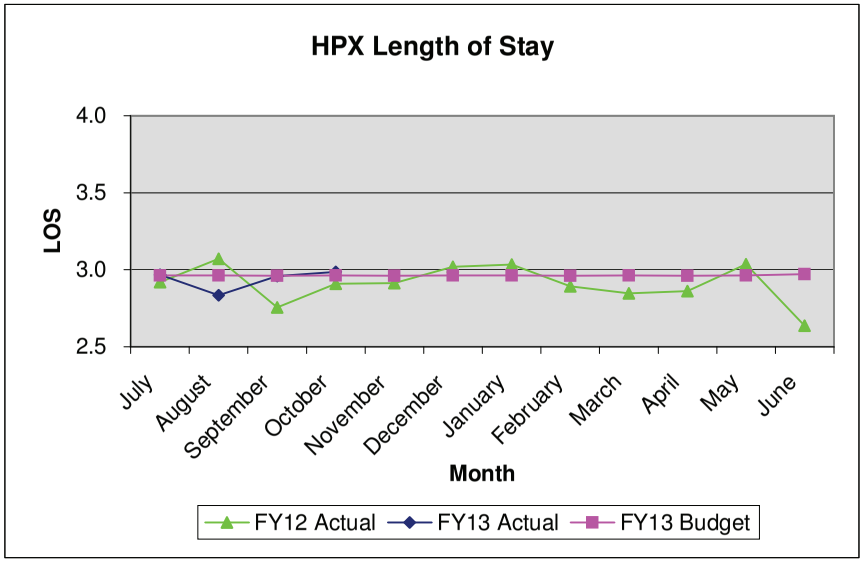


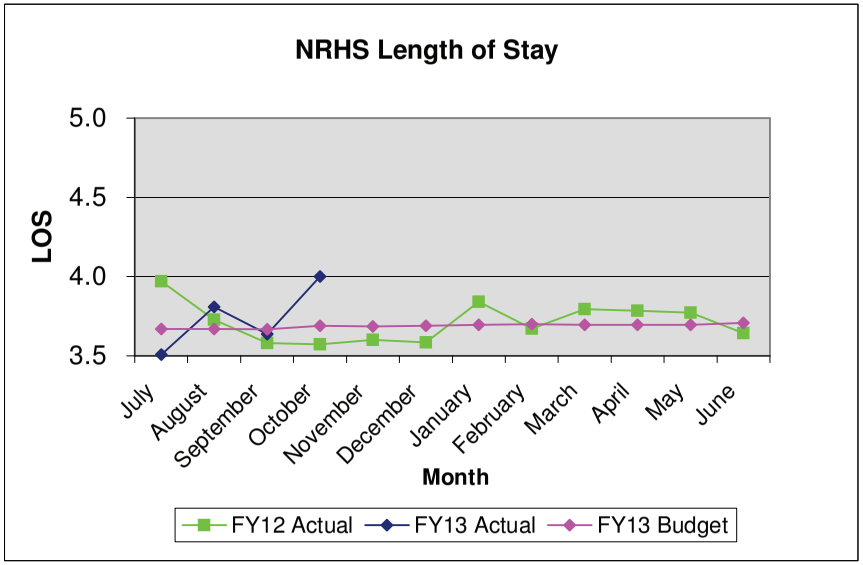


NRHS
Acute Length of Stay

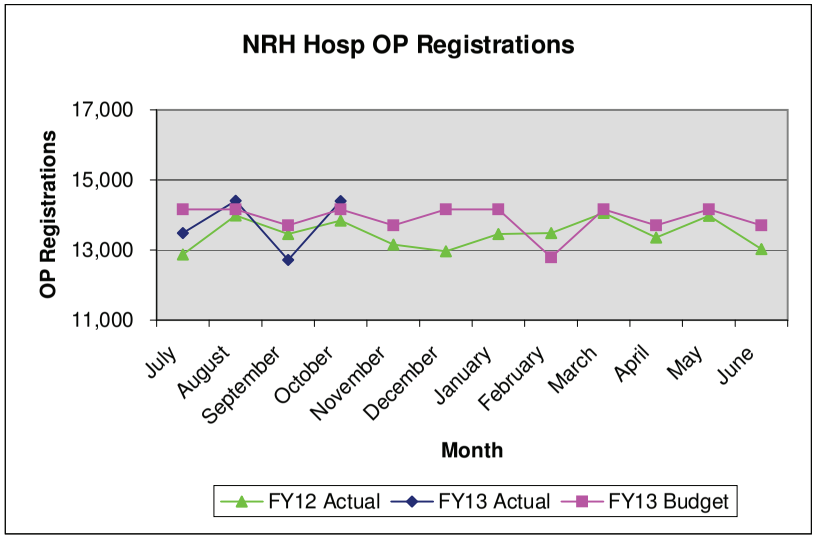


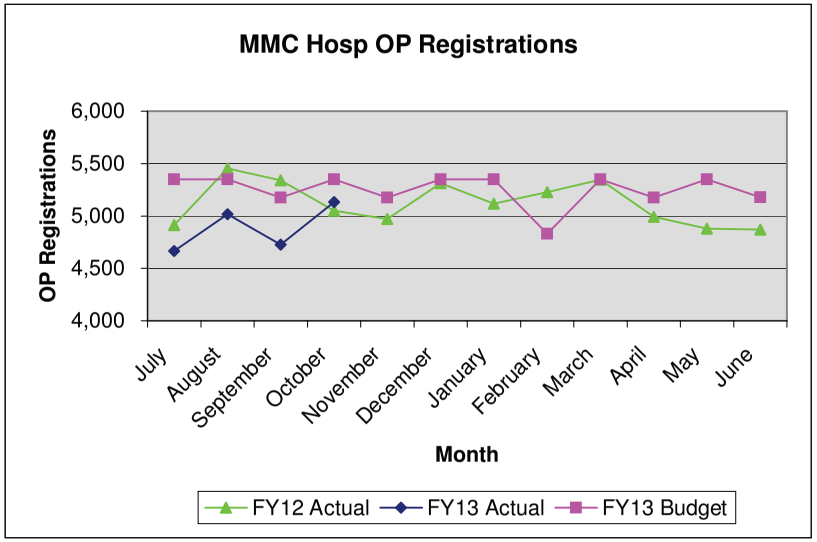


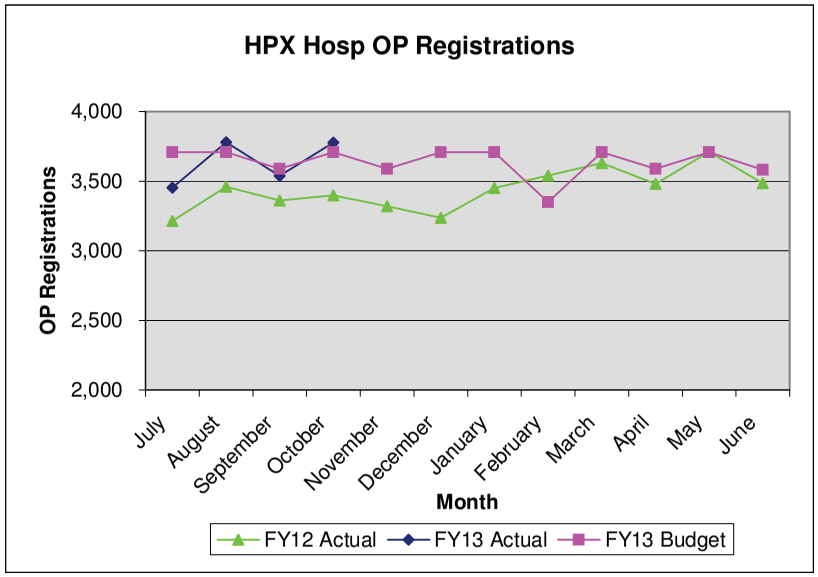


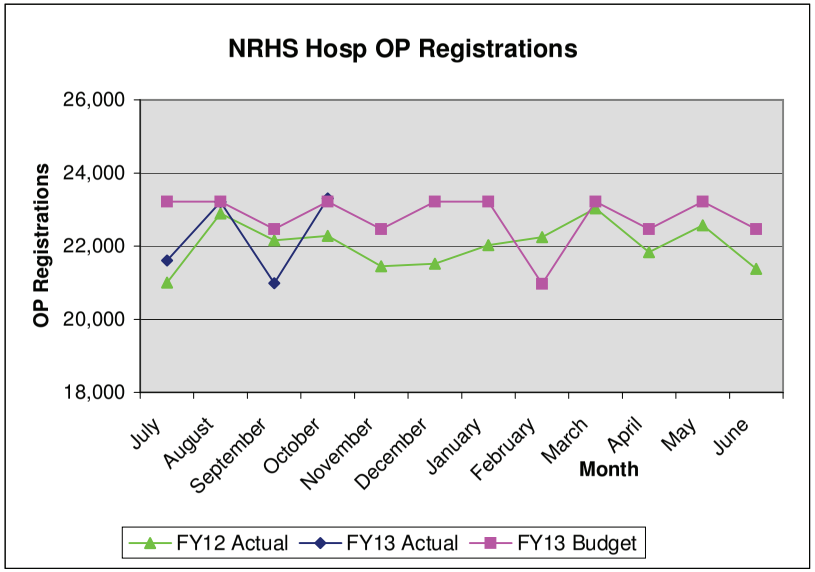


NRHS
Total Hospital Outpatient Registrations

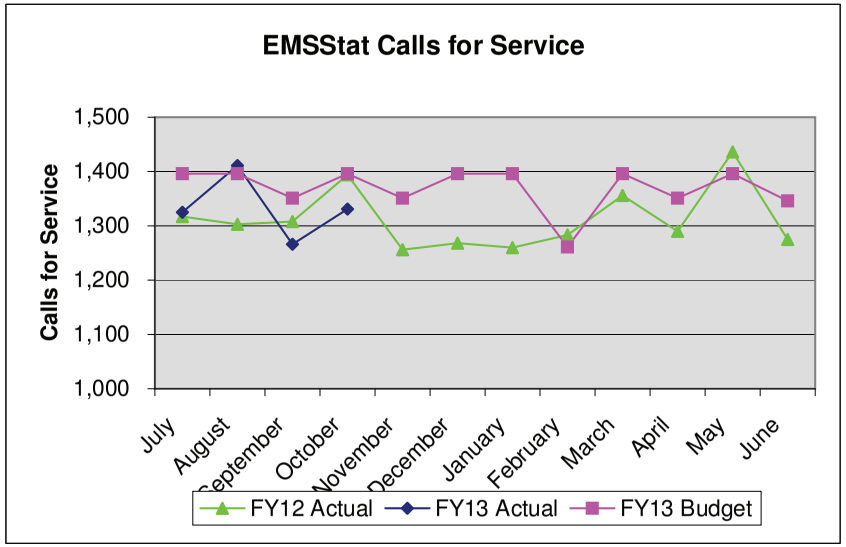


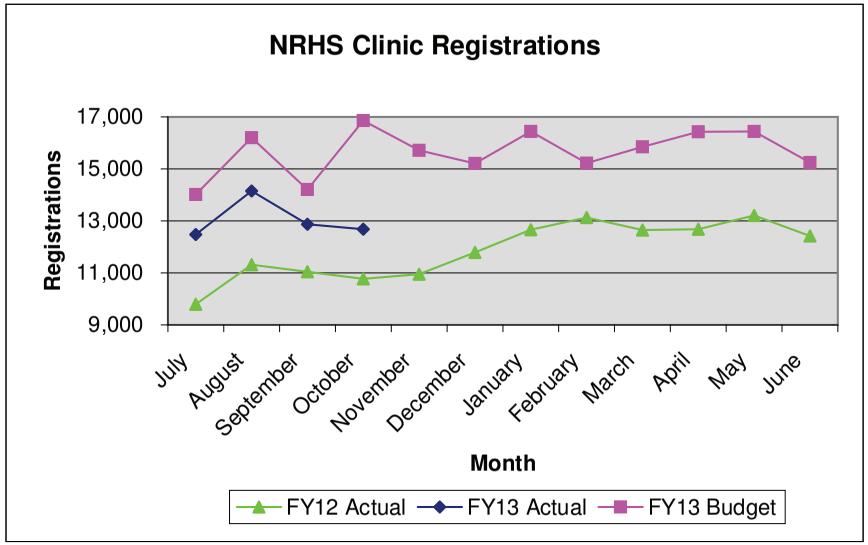




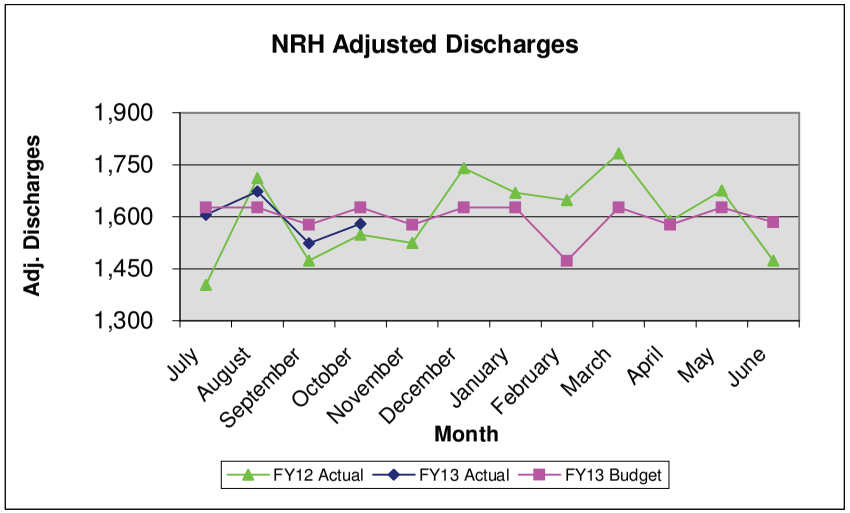


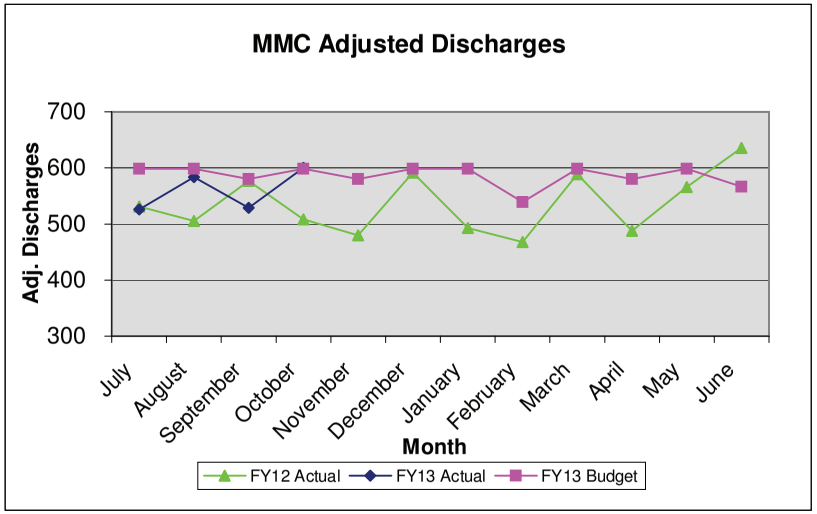
NRHS
Other Outpatient

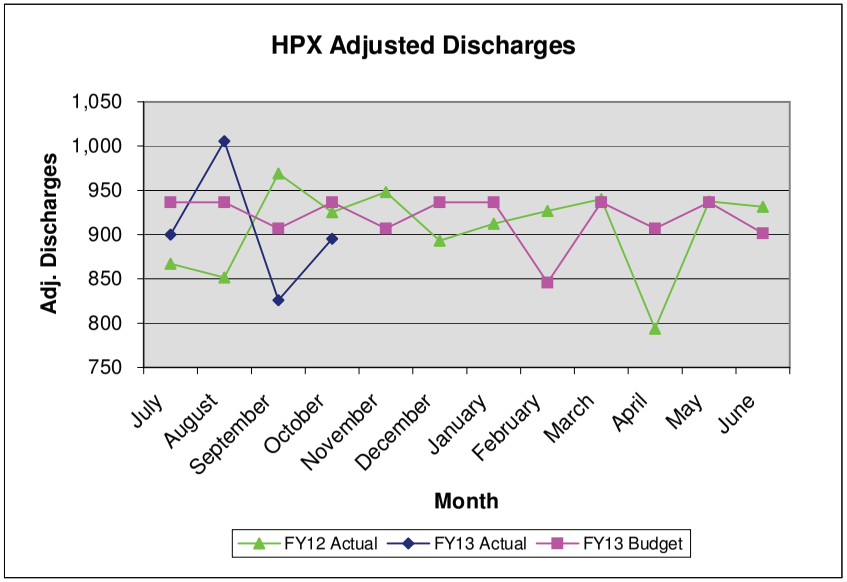


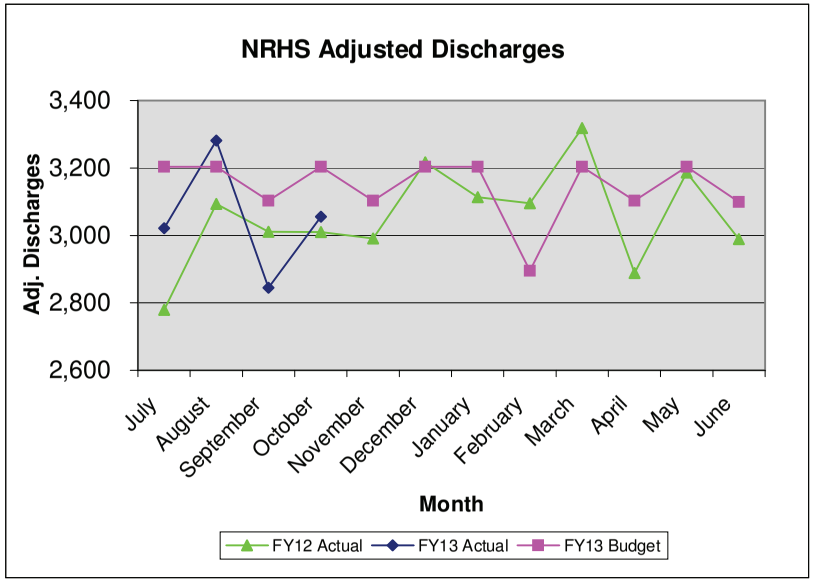


NRHS
Adjusted Discharges

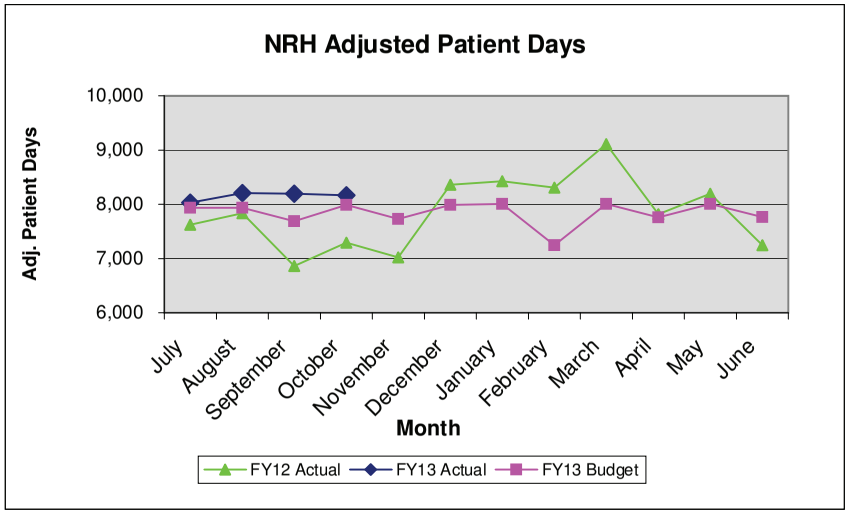


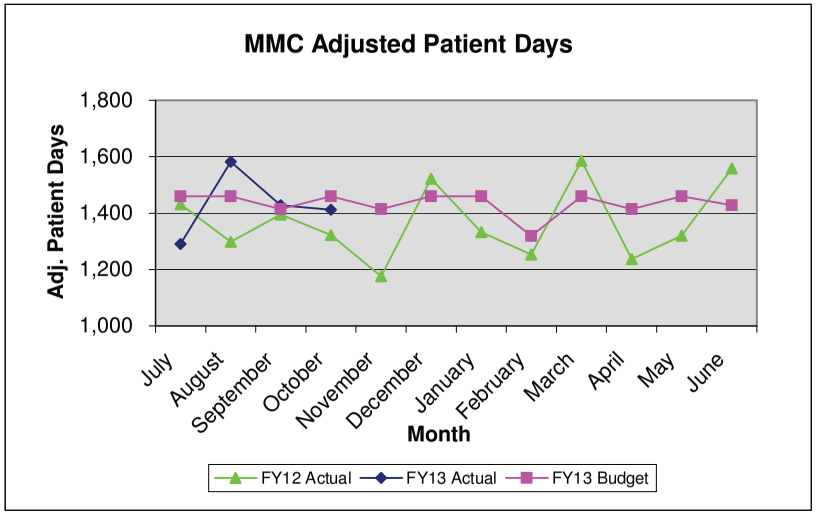


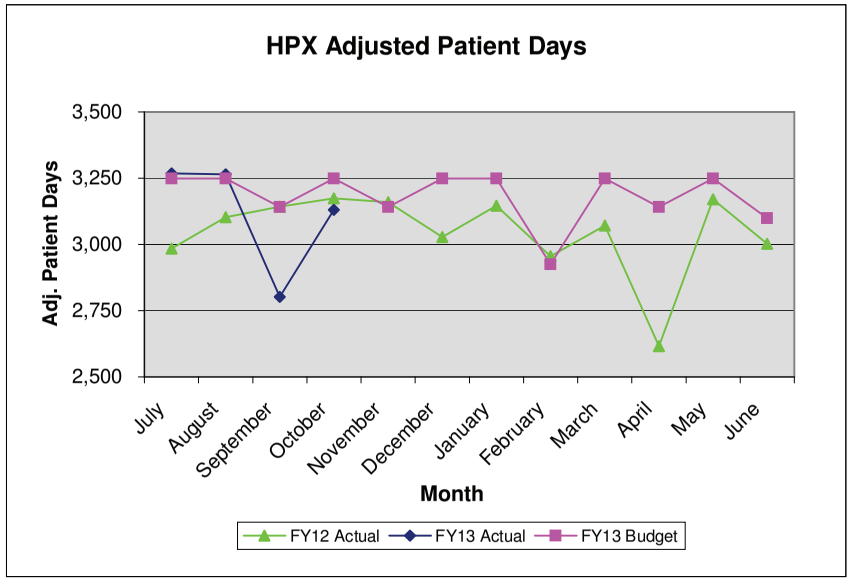


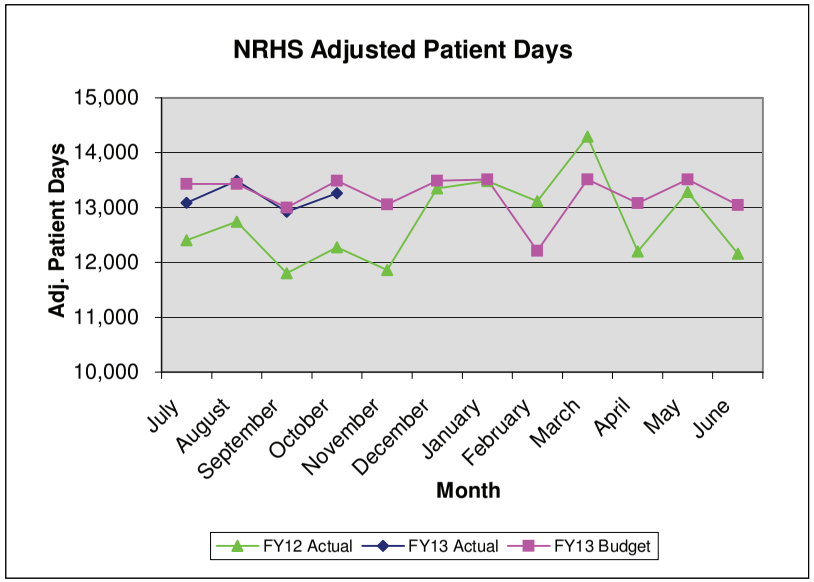


NRHS
Adjusted Patient Days

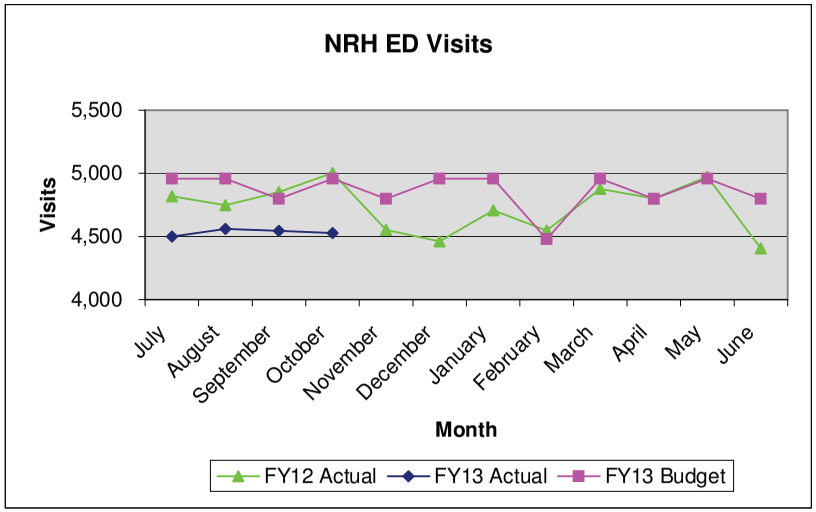


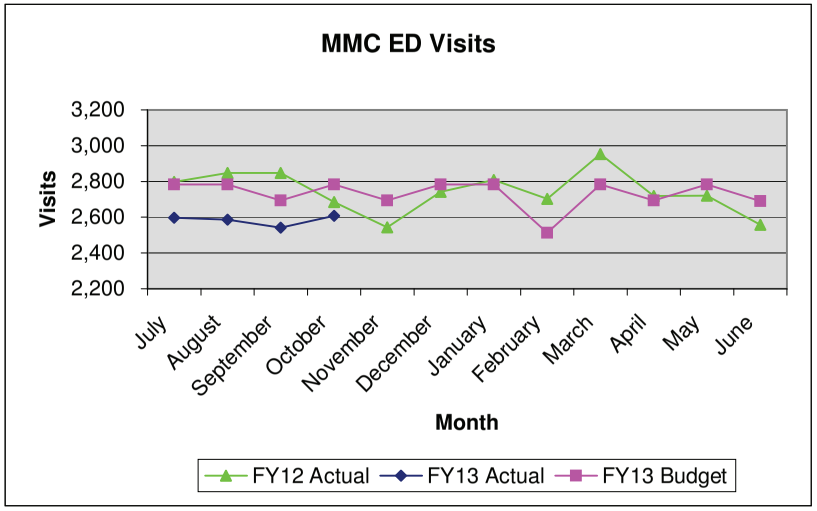


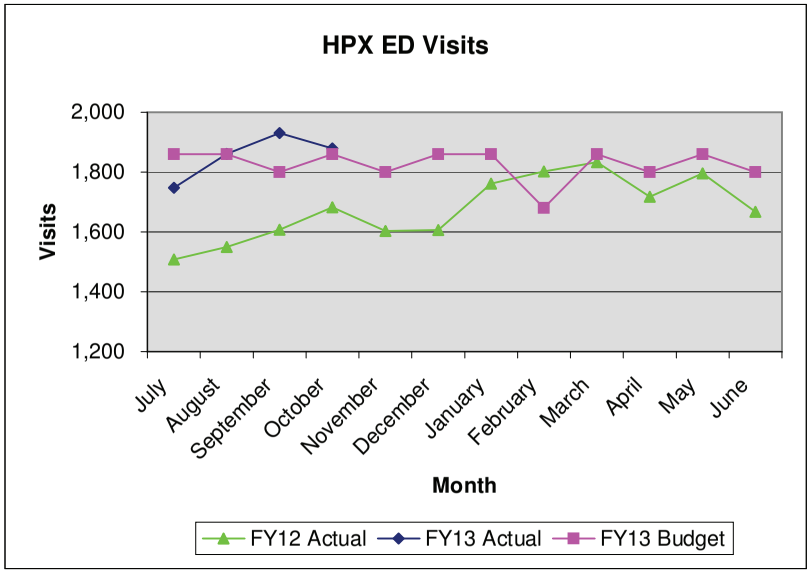


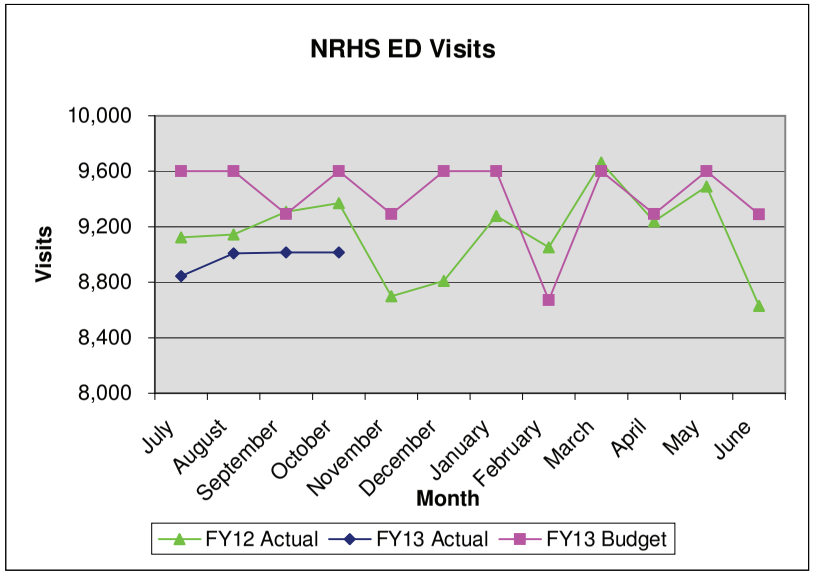


NRHS
Emergency Visits

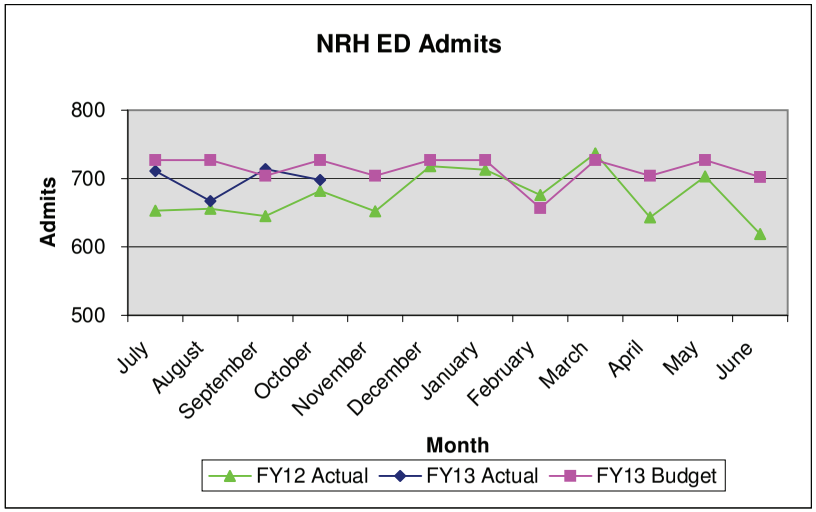


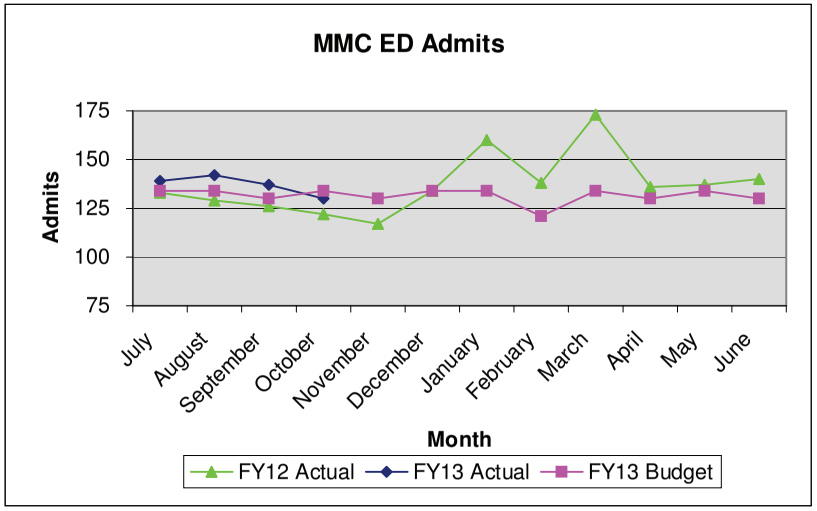


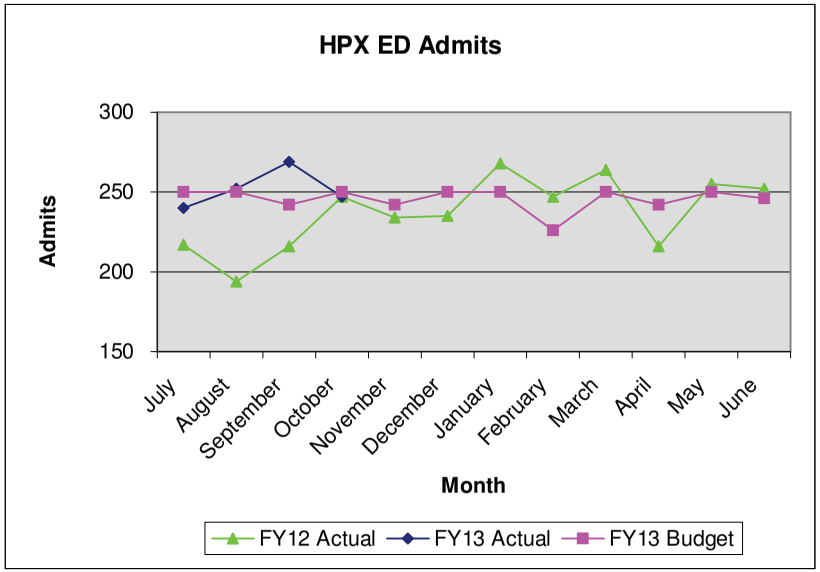


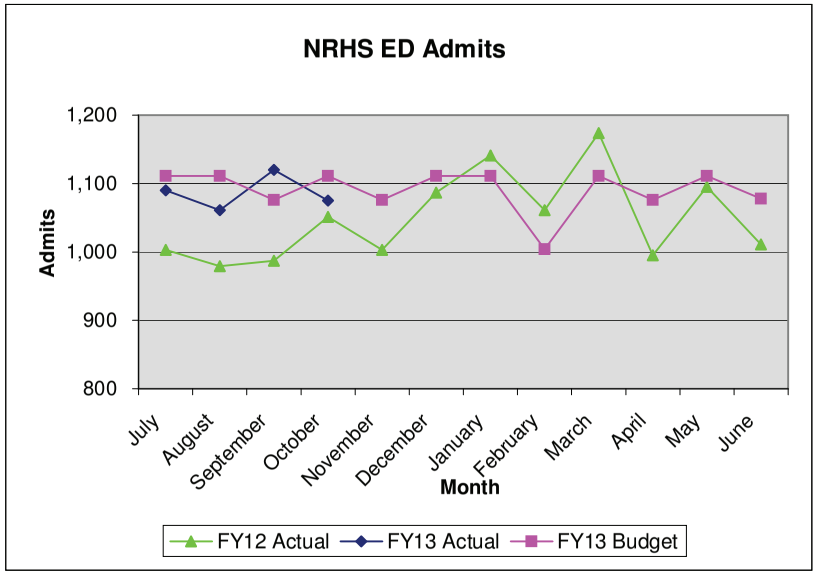


NRHS
Admissions from Emergency Departments

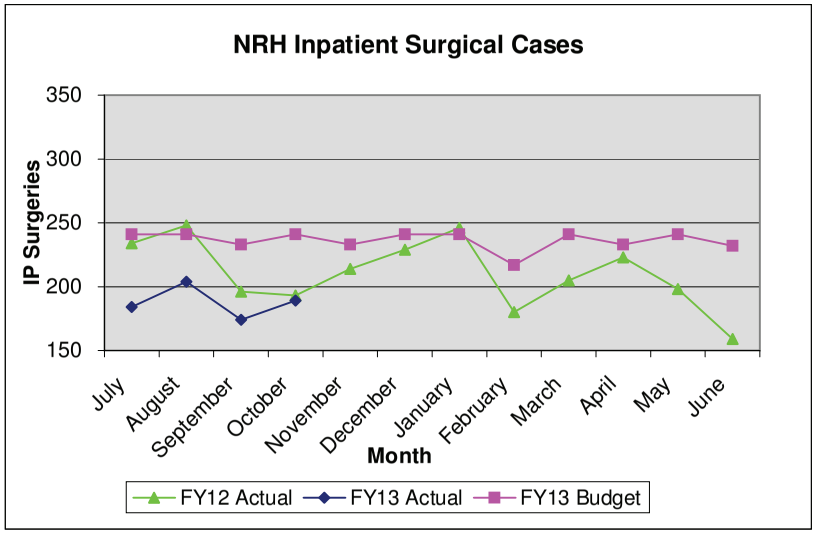


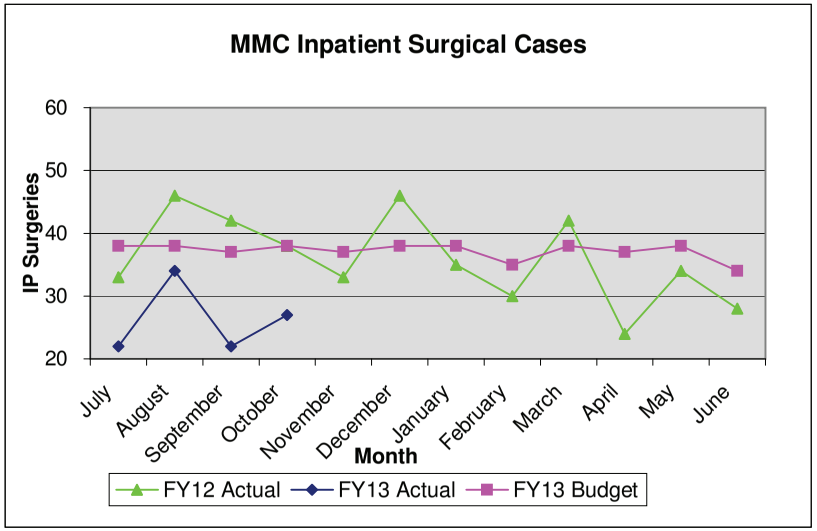


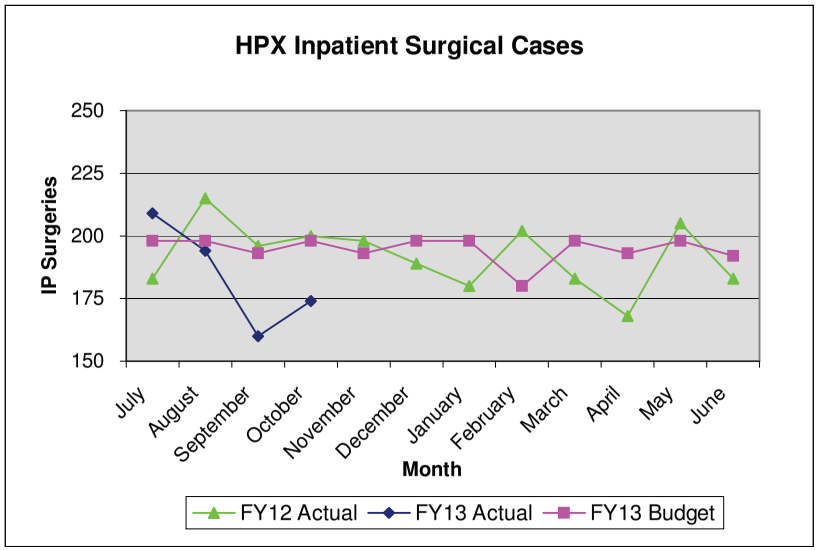


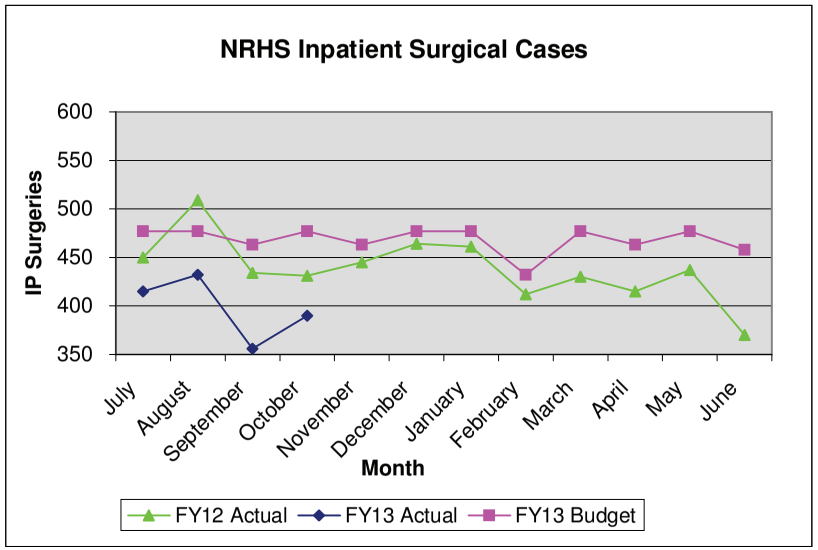


NRHS
Inpatient Surgical Cases









Norman Regional Health System
Board Financial Summary October 2012/FY 2013 YTD

	October 2012				FY 2013 YTD				Desired
	Actual	Budget	Variance	% Variance	Actual	Budget	Variance	% Variance	Trend
Gross Revenue	$115,823,103	$115,724,976	$98,127	0.1%	$443,278,786	$456,879,524	($13,600,738)	-3.0%	
Less: Deductions from Revenue	88,036,060	86,919,281	1,116,779	1.3%	338,313,050	343,552,610	(5,239,560)	-1.5%	
Net Patient Revenue	27,787,043	28,805,695	(1,018,652)	-3.5%	104,965,737	113,326,914	(8,361,177)	-7.4%	Up
Other Revenue	3,308,557	3,257,162	51,395	1.6%	4,565,681	4,510,406	55,275	1.2%	Up
Net Revenue	31,095,600	32,062,857	(967,257)	-3.0%	109,531,418	117,837,320	(8,305,902)	-7.0%	Up
Expenses	28,416,099	28,458,081	(41,982)	-0.1%	109,558,990	112,692,303	(3,133,313)	-2.8%	Down
Net Income from Operations	2,679,501	3,604,776	(925,275)	-25.7%	(27,572)	5,145,017	(5,172,589)	-100.5%	Up
Operating Margin	8.6%	11.2%	-2.6%	-23.2%	0.0%	4.4%	-4.4%	-100.0%	Up
Nonoperating income	(131,707)	342,918	(474,625)	-138.4%	2,386,010	1,443,446	942,564	65.3%	Up
Excess Income over Expenses	$2,547,794	$3,947,694	($1,399,900)	-35.5%	$2,358,437	$6,588,463	($4,230,026)	-64.2%	Up
Excess Margin	8.2%	12.2%	-4.0%	-32.8%	2.1%	5.5%	-3.4%	-61.8%	Up
Bad Debt	$6,110,227	$5,463,585	$646,642	11.8%	$20,682,705	$21,642,765	($960,060)	-4.4%	Down
Charity Care	1,586,965	3,412,720	-$1,825,755	-53.5%	11,766,592	13,517,196	(1,750,604)	-13.0%	Down
Bad Debt & Charity Total	$7,697,192	$8,876,305	-$1,179,113	-13.3%	$32,449,297	$35,159,961	-$2,710,664	-7.7%	Down
Bad Debt & Charity as % of Gross Revenue	6.6%	7.7%	-1.0%	-1.0%	7.3%	7.7%	-0.4%	-0.6%	
Adjusted Discharges	3,039	3,203	(164)	-5.1%	12,202	12,713	(511)	-4.0%	Up
Adjusted Patient Days	13,262	13,491	(230)	-1.7%	52,817	53,356	(539)	-1.0%	Up
Acute Case Mix Index (CMI)	1.3576	1.3295	0.0281	2.1%	1.3040	1.3295	-0.0255	-1.9%	Up
Cost Per Adjusted Discharge	$9,350	$8,885	($466)	-5.2%	$8,979	$8,864	($114)	-1.3%	Down
Inpatient Discharges	1,428	1,510	(82)	-5.4%	5,733	5,993	(260)	-4.3%	Up
Inpatient Days	6,231	6,360	(129)	-2.0%	24,816	25,153	(337)	-1.3%	Up
Acute Average Length of Stay	4.0	3.7	0.3	8.1%	3.7	3.7	0.0	0.0%	Down
Hospital O/P Registations	23,306	23,218	88	0.4%	89,103	92,122	(3,019)	-3.3%	Up
Deductions from Revenue Percentage	76.0%	75.1%	-0.90%	-1.2%	76.3%	75.2%	-1.13%	-1.5%	Down
Accounts Receivable Days					50.7	49.0	(1.7)	-3.5%	Down
Days Cash on Hand					131.4	134.0	-2.59	-1.9%	Up

Norman Regional Health System

Financial Performance Measurements

I. Internal Comparisons

Desired Trend	Benchmark	Goal/Std	FY 2013 Budget	FY '12	FY '13	Oct-12	Qtr 1	Qtr 2
	Profitability							
Up	Operating Margin (%)	2.5%	2.5%	2.5%	0.0%	8.6%	-3.5%	8.6%
Up	Total Margin (%)	3.7%	3.7%	2.5%	2.1%	8.2%	-0.2%	8.2%
Up	EBIDA Operating Margin (%)	12.6%	12.6%	13.5%	10.7%	18.1%	7.8%	18.1%
Up	EBIDA Total Margin (%)	13.7%	13.7%	13.4%	12.7%	17.8%	10.7%	17.8%
	Liquidity and Leverage							
Down	Days in Accounts Receivable-Net	49.0	49.0	55.2	50.7	50.7	54.2	50.7
Up	Cash on Hand (Days)	134.0	134.0	134.5	131.4	131.4	124.7	131.4
Down	Debt to Capitalization Ratio	42%	52.5%	55.0%	54.2%	54.2%	54.6%	54.2%
Up	Maximum Annual Debt Service Requirement	3.00	2.43	2.34	1.94	1.94	1.35	1.94
Up	Debt Service Coverage Ratio	3.00	2.43	2.34	1.94	1.94	1.35	1.94
	Operational							
Up	Occupancy Rate NRH		58.8%	59.6%	58.5%	58.6%	58.4%	58.6%
Up	Occupancy Rate MMC		40.0%	43.3%	37.7%	36.5%	38.1%	36.5%
Up	Occupancy Rate HPX		48.6%	50.8%	47.0%	46.4%	47.2%	46.4%
Up	Occupancy Rate System		54.4%	55.9%	53.5%	53.3%	53.6%	53.3%
Down	Salary Expense as % Net Revenue		41.8%	41.6%	42.4%	38.2%	44.0%	38.2%
Down	Overtime Hours as % Total Paid Hours		2.1%	2.2%	2.4%	2.2%	2.4%	2.2%
Down	Worked FTE's per AOB -NRHS		4.93	4.97	4.94	4.90	4.96	4.90
Down	Total Expenses as % Net Revenue		97.5%	97.5%	100.0%	91.4%	103.5%	91.4%
Down	Cost per Adjusted Discharges		$8,903	$8,559	$8,979	$9,350	$8,855	$9,350
Up	Acute Case Mix Index (CMI)		1.3295	1.3295	1.3040	1.3576	1.2751	1.3576

shaded area denotes unfavorable to budget

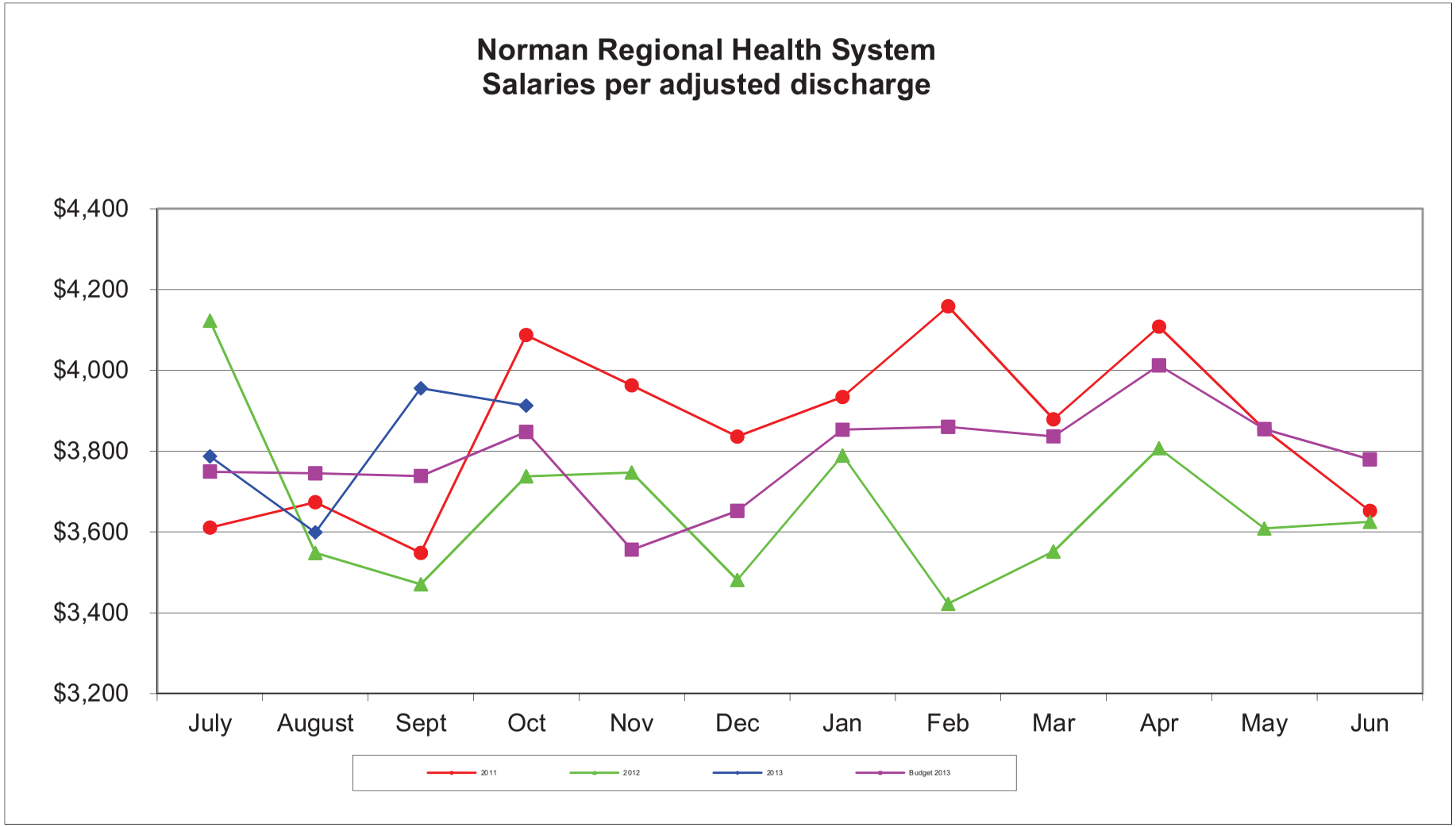
II. External Comparisons

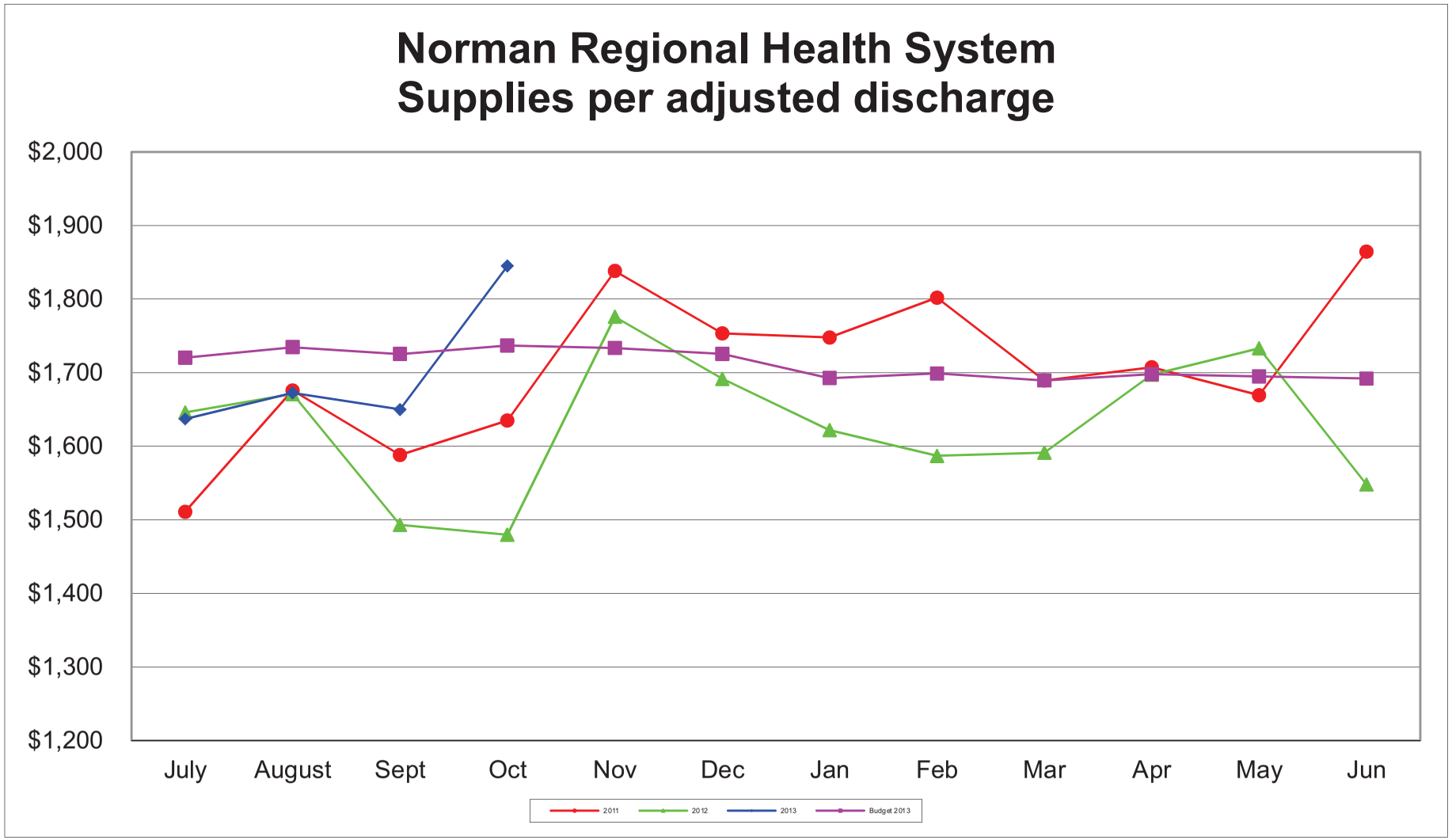
	NRHS FY 2013	S&P BBB+	S&P BBB	Moody's Baa1	Moody's Baa2	Fitch BBB+	Fitch BBB
Operating Margin	0.0%	2.5%	2.2%	1.7%	1.5%	2.0%	1.7%
Total Margin	2.1%	3.8%	2.8%	4.0%	3.3%	3.4%	2.0%
EBIDA Operating Margin (%)	10.7%	9.5%	10.1%	7.9%	8.8%	8.5%	8.6%
EBIDA Total Margin	12.7%	10.6%	10.8%			10.0%	9.2%
Days in Accounts Receivable-Net	50.7	43.5	45.7	45	43.1	45.1	46.5
Cash on Hand (Days)	131.4	148.2	131.3	133	124.9	152.1	110.7
Maximum Annual Debt Service Requirement	1.94	3.20	2.90	3.70	2.90		
Cash and Investments to Debt Ratio	48.5%	113.4%	87.1%	91.6%	74.6%	87.4%	75.4%
Debt to Capitalization Ratio	54.2%	38.7%	38.7%	47.7%	50.4%	48.8%	49.9%

shaded area denotes unfavorable to external comparison (S&P BBB+)

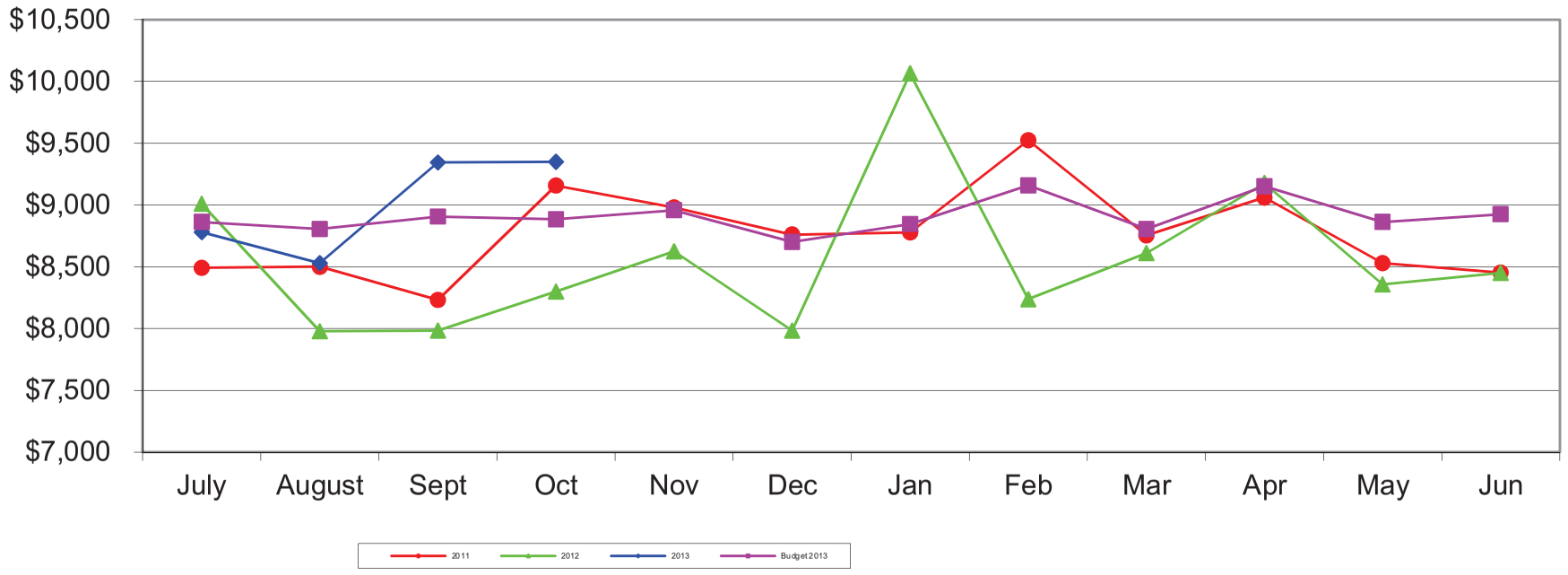
Norman Regional Health System
Revenue Analysis
For October 2012

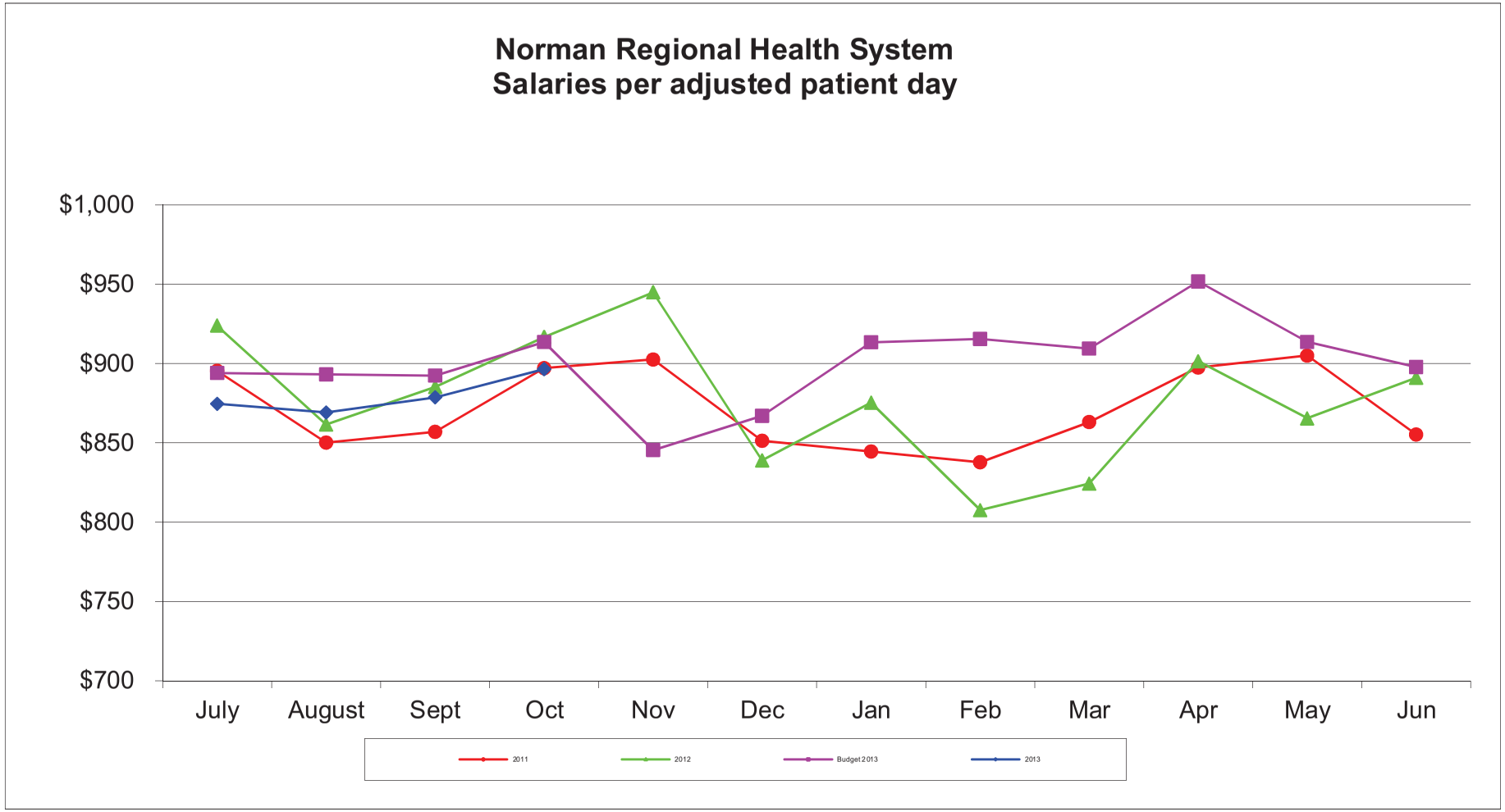
	Month Actual	Month Budget	Variance	Variance %	FY 13 YTD Actual	FY 13 YTD Budget	Variance	Variance %	FY12 Actual
Inpatient Gross Revenue	54,134,606	54,262,670	(128,064)	-0.2%	208,273,981	214,392,459	(6,118,478)	-2.9%	600,188,499
Discharges	1,428	1,510	(82)	-5.4%	5,733	5,993	(260)	-4.3%	17,556
Inpatient Gross Revenue/Discharges	37,909.39	35,935.54	1,973.84	5.5%	36,328.97	35,773.81	555.16	1.6%	34,187.09
Inpatient Gross Revenue	54,134,606	54,262,670	(128,064)	-0.2%	208,273,981	214,392,459	(6,118,478)	-2.9%	600,188,499
Patient Days	6,231	6,360	(129)	-2.0%	24,816	25,153	(337)	-1.3%	73,218
Inpatient Gross Revenue/Patient Days	8,687.95	8,531.87	156.08	1.8%	8,392.73	8,523.53	(130.80)	-1.5%	8,197.28
Total Net Patient Revenue	27,787,043	28,805,695	(1,018,652)	-3.5%	104,965,737	113,326,914	(8,361,177)	-7.4%	317,470,678
Adjusted Discharges	3,039	3,203	(164)	-5.1%	12,202	12,713	(511)	-4.0%	37,033
Net Revenue/Adjusted Discharges	9,142.65	8,993.01	149.64	1.7%	8,602.48	8,914.41	(311.93)	-3.5%	8,572.64
Total Net Patient Revenue	27,787,043	28,805,695	(1,018,652)	-3.5%	104,965,737	113,326,914	(8,361,177)	-7.4%	317,470,678
Adjusted Patient Days	13,262	13,491	(230)	-1.7%	52,817	53,356	(539)	-1.0%	154,447
Net Revenue/Adjusted Patient Days	2,095.28	2,135.13	(39.85)	-1.9%	1,987.35	2,123.96	(136.62)	-6.4%	2,055.53


Norman Regional Health System
Salaries per adjusted discharge
$4,400
$4,200
$4,000
$3,800
$3,600
$3,400
$3,200
July
August
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2011
2012
2013
Budget 2013

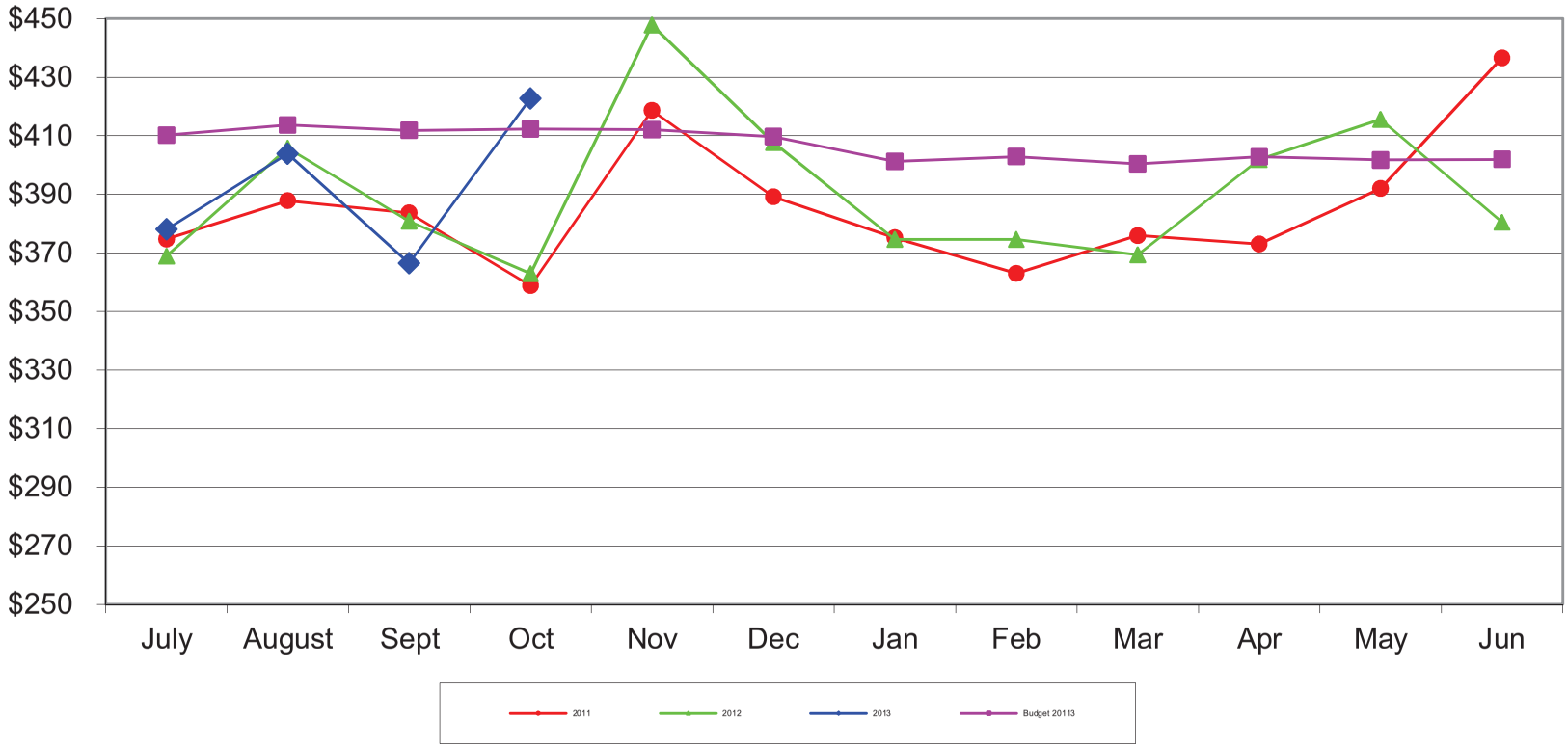

Norman Regional Health System
Supplies per adjusted discharge
$2,000
$1,900
$1,800
$1,700
$1,600
$1,500
$1,400
$1,300
$1,200
July
August
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2011
2012
2013
Budget 2013

Norman Regional Health System
Operating Expense excluding bad debt per adjusted discharge

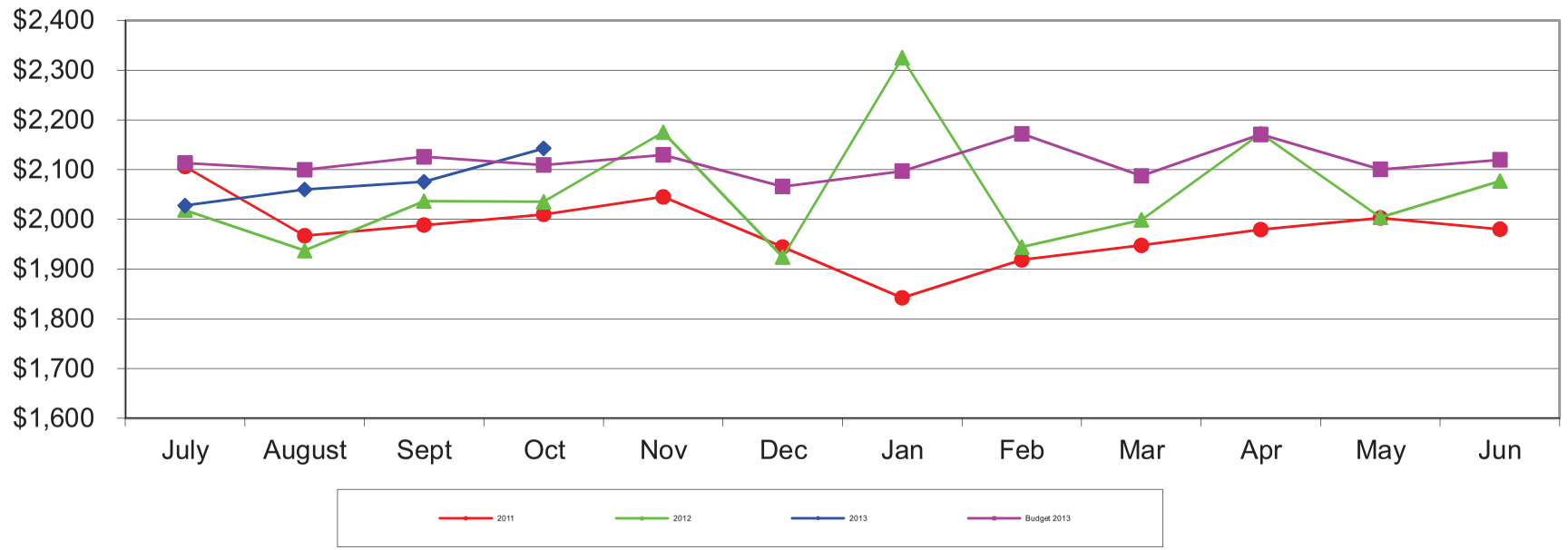



Norman Regional Health System
Salaries per adjusted patient day
$1,000
$950
$900
$850
$800
$750
$700
July
August
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2011
2012
Budget 2013
2013

Norman Regional Health System
Supplies per adjusted patient day



Norman Regional Health System
Operating Expense per adjusted patient day



NORMAN REGIONAL HEALTH SYSTEM
Statement of Operations
For the Months Ended 10/31/12

	ACTUAL 10/31/12	%	BUDGET 10/31/12	%	ACTUAL 09/30/12	%	ACTUAL 10/31/11	%
GROSS PATIENT REVENUE								
Inpatient Revenue	$ 54,134,606	46.7%	$ 54,262,670	46.9%	$ 50,459,235	47.5%	$ 48,087,182	47.0%
Outpatient Revenue	55,229,748	47.7%	54,709,065	47.3%	49,948,536	47.0%	49,027,579	47.9%
Other Outpatient Revenue	867,939	0.7%	886,696	0.8%	765,660	0.7%	787,077	0.8%
Clinic Income	5,590,811	4.8%	5,866,545	5.1%	5,078,455	4.8%	4,456,949	4.4%
	115,823,103	100.0%	115,724,976	100.0%	106,251,887	100.0%	102,358,787	100.0%
DEDUCTIONS FROM REVENUE								
Medicare Allowances	39,576,231	(34.2)%	36,271,942	(31.3)%	34,875,583	(32.8)%	33,760,021	(33.0)%
Medicaid Allowances	10,106,186	(8.7)%	10,002,918	(8.6)%	9,867,566	(9.3)%	7,629,777	(7.5)%
Insurance Adjustments	25,842,097	(22.3)%	27,850,314	(24.1)%	24,376,450	(22.9)%	24,427,360	(23.9)%
Charity Adjustments	1,586,965	(1.4)%	3,412,720	(2.9)%	3,485,262	(3.3)%	3,423,228	(3.3)%
Bad Debt Expense	6,110,227	(5.3)%	5,463,585	(4.7)%	4,590,215	(4.3)%	3,446,436	(3.4)%
Government Audit Adjustments	679,921	(0.6)%	0	0.0%	363,399	(0.3)%	0	0.0%
Operational Denial Adjustments	487,802	(0.4)%	0	0.0%	733,139	(0.7)%	0	0.0%
Administrative Adjustments	111,484	(0.1)%	527,020	(0.5)%	124,039	(0.1)%	419,281	(0.4)%
Other Adjustments	50,756	0.0%	0	0.0%	32,254	0.0%	0	0.0%
O/P External Adjustments	3,484,392	(3.0)%	3,390,782	(2.9)%	3,058,172	(2.9)%	2,565,280	(2.5)%
	88,036,060	(76.0)%	86,919,281	(75.1)%	81,506,080	(76.7)%	75,671,381	(73.9)%
NET PATIENT REVENUE	27,787,043	24.0%	28,805,695	24.9%	24,745,808	23.3%	26,687,405	26.1%
OTHER OPERATING REVENUE	3,308,557		3,257,162		427,082		3,090,035	
NET REVENUE	31,095,600	100.0%	32,062,857	100.0%	25,172,890	100.0%	29,777,441	100.0%
EXPENSES								
Salaries	11,889,816	(38.2)%	12,324,455	(38.4)%	11,352,608	(45.1)%	11,354,600	(38.1)%
Employee Benefits	2,145,383	(6.9)%	2,087,643	(6.5)%	1,821,762	(7.2)%	1,632,365	(5.5)%
Physician Fees	736,662	(2.4)%	635,599	(2.0)%	765,981	(3.0)%	834,645	(2.8)%
Professional Services	250,062	(0.8)%	192,441	(0.6)%	340,936	(1.4)%	62,020	(0.2)%
Supplies	5,606,923	(18.0)%	5,562,955	(17.4)%	4,735,513	(18.8)%	4,494,887	(15.1)%
Purchased Services	1,428,616	(4.6)%	1,348,886	(4.2)%	1,548,915	(6.2)%	1,383,364	(4.6)%
Leases	377,977	(1.2)%	356,585	(1.1)%	341,142	(1.4)%	318,232	(1.1)%
Utilities	376,062	(1.2)%	389,273	(1.2)%	422,011	(1.7)%	341,445	(1.1)%
Depreciation	2,007,257	(6.5)%	1,968,808	(6.1)%	1,981,459	(7.9)%	2,014,794	(6.8)%
Interest Expense	949,094	(3.1)%	951,410	(3.0)%	950,704	(3.8)%	964,813	(3.2)%
Miscellaneous	2,648,247	(8.5)%	2,640,026	(8.2)%	2,558,718	(10.2)%	1,811,038	(6.1)%
	28,416,099	(91.4)%	28,458,081	(88.8)%	26,819,748	(106.5)%	25,212,201	(84.7)%
OPERATING INCOME	2,679,501	8.6%	3,604,776	11.2%	(1,646,859)	(6.5)%	4,565,240	15.3%
NON OPERATING INCOME								
Contributions	0		5,417		0		0	
Realized Investment Income	323,941		114,223		600,835		(198,744)	
Unrealized Investment Income	(455,648)		223,278		633,301		2,962,859	
TOTAL NON-OPERATING INCOME	(131,707)		342,918		1,234,136		2,764,115	
EXCESS REVENUE OVER EXPENSES	$ 2,547,794	8.2%	$ 3,947,694	12.2%	$ (412,723)	(1.6)%	$ 7,329,355	22.5%

NORMAN REGIONAL HEALTH SYSTEM
Statement of Operations
For the Months Ended 10/31/12

	ACTUAL 10/31/12	%	BUDGET 10/31/12	%	ACTUAL 09/30/12	%	ACTUAL 10/31/11	%
CAPITAL CONTRIBUTIONS	0		0		117,538		0	
CHANGE IN NET ASSETS	$ 2,547,794		$ 3,947,694		$ (295,185)		$ 7,329,355	

Norman Regional Health System
Statement of Operations
For the Months Ended OCT 2012

	YTD ACTUAL 10/31/12	%	YTD BUDGET 10/31/12	%	PRIOR YTD 10/31/11	%
GROSS PATIENT REVENUE						
Inpatient Revenue	$ 208,273,981	47.0%	$ 214,392,459	46.9%	$ 195,584,863	47.4%
Outpatient Revenue	210,855,166	47.6%	217,463,722	47.6%	196,185,065	47.6%
Other Outpatient Revenue	3,381,202	0.8%	3,333,095	0.7%	3,116,160	0.8%
Clinic Income	20,768,438	4.7%	21,690,248	4.7%	17,612,703	4.3%
	443,278,786	100.0%	456,879,524	100.0%	412,498,791	100.0%
DEDUCTIONS FROM REVENUE						
Medicare Allowances	147,279,210	(33.2)%	143,596,859	(31.4)%	131,150,865	(31.8)%
Medicaid Allowances	37,803,190	(8.5)%	39,655,605	(8.7)%	37,951,917	(9.2)%
Insurance Adjustments	103,228,926	(23.3)%	110,434,329	(24.2)%	99,450,430	(24.1)%
Charity Adjustments	11,766,592	(2.7)%	13,517,196	(3.0)%	10,835,398	(2.6)%
Bad Debt Expense	20,809,696	(4.7)%	21,642,765	(4.7)%	20,530,239	(5.0)%
Government Audit Adjustments	1,591,861	(0.4)%	0	0.0%	0	0.0%
Operational Denial Adjustments	2,083,762	(0.5)%	0	0.0%	0	0.0%
Administrative Adjustments	663,770	(0.1)%	2,087,807	(0.5)%	1,863,504	(0.5)%
Other Adjustments	95,693	0.0%	0	0.0%	0	0.0%
O/P External Adjustments	12,990,351	(2.9)%	12,618,049	(2.8)%	10,247,526	(2.5)%
	338,313,050	(76.3)%	343,552,610	(75.2)%	312,029,878	(75.6)%
NET PATIENT REVENUE	104,965,737	23.7%	113,326,914	24.8%	100,468,914	24.4%
OTHER OPERATING REVENUE	4,565,681		4,510,406		4,243,333	
NET REVENUE	109,531,418	100.0%	117,837,320	100.0%	104,712,247	100.0%
EXPENSES						
Salaries	46,412,702	(42.4)%	47,930,838	(40.7)%	44,923,783	(42.9)%
Employee Benefits	7,523,101	(6.9)%	8,282,510	(7.0)%	7,497,139	(7.2)%
Physician Fees	2,812,917	(2.6)%	2,468,221	(2.1)%	1,364,323	(1.3)%
Professional Services	1,362,612	(1.2)%	801,270	(0.7)%	854,925	(0.8)%
Supplies	20,737,863	(18.9)%	21,983,617	(18.7)%	19,043,748	(18.2)%
Purchased Services	5,456,573	(5.0)%	5,585,403	(4.7)%	4,850,344	(4.6)%
Leases	1,354,907	(1.2)%	1,415,241	(1.2)%	1,279,937	(1.2)%
Utilities	1,774,514	(1.6)%	1,765,853	(1.5)%	1,665,758	(1.6)%
Depreciation	7,995,206	(7.3)%	7,860,476	(6.7)%	8,005,345	(7.6)%
Interest Expense	3,804,269	(3.5)%	3,840,445	(3.3)%	3,882,465	(3.7)%
Miscellaneous	10,324,326	(9.4)%	10,758,429	(9.1)%	7,164,458	(6.8)%
	109,558,990	(100.0)%	112,692,303	(95.6)%	100,532,225	(96.0)%
OPERATING INCOME	(27,573)	0.0%	5,145,017	4.4%	4,180,022	4.0%
NON OPERATING INCOME						
Contributions	0		21,668		35,000	
Realized Investment Income	1,371,004		528,666		349,693	
Unrealized Investment Income	1,015,006		893,112		(2,811,413)	
TOTAL NON OPERATING INCOME	2,386,010		1,443,446		(2,426,720)	
EXCESS REVENUE OVER EXPENSES	$ 2,358,437	2.1%	$ 6,588,463	5.5%	$ 1,753,302	1.7%

Norman Regional Health System
Statement of Operations
For the Months Ended OCT 2012

	YTD ACTUAL 10/31/12	%	YTD BUDGET 10/31/12	%	PRIOR YTD 10/31/11	%
CAPITAL CONTRIBUTIONS	117,538		0		0	
CHANGE IN NET ASSETS	$ 2,475,975		$ 6,588,463		$ 1,753,302	

Norman Regional Health System
Statement of Operations - EBIDA
Year to date for the periods ended

	Comp. to Bud. Fav	Comp. to Bud. Unfav	YTD Actual 10/31/2012	%	YTD Budget 10/31/2012	%	Prior YTD 10/31/2011	%
EBIDA - Operating income margin:								
Net Revenue			$ 109,531,418		$ 117,837,320		$ 104,712,247	
Operating Income			(27,573)	0.0%	5,145,017	4.4%	4,180,022	4.0%
Depreciation & Amortization			7,995,206	7.3%	7,860,476	6.7%	8,005,345	7.6%
Interest			3,804,269	3.5%	3,840,445	3.3%	3,882,465	3.7%
EBIDA - Operating income			11,771,902	10.7%	16,845,938	14.3%	16,067,832	15.3%
EBIDA Total margin:								
Net revenue			109,531,418		117,837,320		104,712,247	
Non-operating income			2,386,010		1,443,446		(2,426,720)	
Net revenue plus non-operating income			111,917,428		119,280,766		102,285,527	
Excess revenue over expense			2,358,437	2.1%	6,588,463	5.5%	1,753,302	1.7%
Depreciation and Amortization			7,995,206	7.1%	7,860,476	6.6%	8,005,345	7.8%
Interest			3,804,269	3.4%	3,840,445	3.2%	3,882,465	3.8%
Net EBIDA			14,157,912	12.7%	18,289,384	15.3%	13,641,112	13.3%

Norman Regional Health System
Analysis of Income From Investments
As of October 31, 2012

Description	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
Income from Investments - Realized													
Interest Income-A/R	307	2,633	2,143	4,375									9,459
Interest Income-Bank Accounts	10,074	10,523	10,120	9,579									40,295
Interest Income-Certificate of Deposit	-		-	-									-
Interest Income-Bank of Oklahoma Fees	-		-	-									-
Bernstein Investment Income	145,942	140,562	254,635	36,489									577,627
Investment Earnings-Norman Medical Plaza	-	-	-	-									-
Investment Earnings-National Surgery Center	-	8,664	-	-									8,664
Investment Earnings-Oklahoma Heart Hospital	-	53,924	181,236	104,112									339,272
Investment Earnings-Axis Practice Solutions	-	-	2,231	(5,557)									(3,327)
Investment Earnings-Oklahoma Sleep Associates	-	18,354	81,945	56,027									156,326
Investment Earnings-ICO Norman	-	13,289	-	-									13,289
Investment Earnings-NPHO	-	-	-	-									-
Investment Earnings-Medical Plaza Endoscopy Unit	-	-	-	-									-
Investment Earnings-CT Center of Norman	-	-	-	-									-
Investment Earnings-CT Leasing of Norman	-	-	-	-									-
Investment Earnings-MPW LLC	25,031	24,945	22,992	57,050									130,018
Investment Earnings-Cath Lab	-	-	-	-									-
Investment Earnings-Norman Specialty Hospital	-	26,303	45,534	91,867									163,704
Gain/Loss on Sale of Investment	-	-	-	-									-
Investment Management Fees	-	(34,324)	-	(30,000)									(64,324)
Total Income from Investments - Realized	181,354	264,874	600,835	323,941	0	-	0	0	0	0	0	0	1,371,004
Income from Investments - Unrealized													
Investment Earnings-Bernstein	181,866	899,188	634,756	(457,507)									1,258,304
Investment Earnings-Other	(280,835)	37,133	(1,456)	1,859									(243,298)
Total Income from Investments - Unrealized	(98,969)	936,321	633,301	(455,648)	0	-	0	0	0	0	0	0	1,015,006
Total Investment Income	82,385	1,201,195	1,234,136	(131,707)	0	-	0	0	0	0	0	0	2,386,010

NORMAN REGIONAL HEALTH SYSTEM
BALANCE SHEET
As of October 31, 2012

	Current Year Unaudited FY 2013	Last Year Audited FY 2012
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 49,782,218	$ 51,072,795
Investments	58,936,518	56,578,866
Accounts Receivable less Allowances	43,434,190	46,884,233
Other Receivables	7,247,531	3,664,996
Inventory	10,910,188	10,491,624
Prepaid Expenses	5,199,111	2,719,349
	175,509,757	171,411,862
NONCURRENT CASH AND INVESTMENTS		
Held by Trustee - Interest Accounts	1,747,137	3,546,872
Held by Trustee - Principal Accounts	747,906	3,579,167
Held by Trustee - Reserve Accounts	18,178,153	18,178,153
Held by Trustee - Project Fund	-	-
Held by Trustee - CD's	78,336	78,336
	20,751,532	25,382,527
LONG-TERM ASSETS		
CAPITAL ASSETS		
Land and Land Improvements	9,679,681	9,679,681
Buildings, Improvements, and Fixed Equipment	270,266,961	269,839,602
Major Moveable Equipment	179,174,281	175,102,985
Construction in Progress	614,420	340,531
	459,735,342	454,962,798
Accumulated Depreciation	(227,336,936)	(219,441,971)
	232,398,406	235,520,827
OTHER ASSETS		
Miscellaneous Assets	25,736,383	30,495,254
	$454,396,078	$462,810,471

	Current Year Unaudited FY 2013	Last Year Audited FY 2012
LIABILITIES AND NET ASSETS		
CURRENT LIABILITES		
Accounts Payable	$ 15,377,163	$ 14,819,127
Accrued Payroll and Expenses	14,981,847	21,008,209
Deferred Revenue	2,180,297	-
Accrued Interest Payable	1,777,410	3,552,309
Insurance Reserves	3,897,459	4,711,065
Accrued Pension Benefits	2,627,584	2,182,476
Current Maturities of Long-Term Debt	7,282,359	7,315,501
	48,124,120	53,588,687
LONG-TERM LIABILITIES		
Bonds Payable	209,270,000	213,760,000
Other Long-Term Debt	7,443,088	8,432,611
Loss on Defeasance of Bonds	(1,767,329)	(1,821,051)
Estimated Self-Insurance Costs	1,868,000	1,868,000
	216,813,760	222,239,560
NET ASSETS		
Beginning Fund Balance	186,982,224	186,982,224
Change in Net Assets	2,475,975	-
	189,458,198	186,982,224
	$454,396,078	$462,810,471

NORMAN REGIONAL HEALTH SYSTEM
Statement of Cash Flow
For The Four Months Ended October 31, 2012

	Unaudited 4 Months FY 2013	Audited 12 months FY 2012
CASH FLOW FROM OPERATING ACTIVITIES		
Receipts from and on behalf of patients	$ 107,013,542	$ 312,283,583
Payments to suppliers and contractors	(54,310,097)	(148,254,260)
Payments to employees	(52,249,525)	(128,997,788)
Other receipts and payments, net	3,470,458	8,603,715
Net cash provided by (used in) operating activities	3,924,377	43,635,250
CASH FLOW FROM NONCAPITAL FINANCING ACTIVITIES		
Gifts from NRHS Foundation	0	270,000
Net cash provided by (used in) noncapital financing activities	0	270,000
CASH FLOW FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Capital grants and gifts	117,538	322,779
Proceeds from disposal of capital assets	(949)	625,192
Principal paid on long-term debt	(5,458,942)	(7,306,257)
Interest paid on long-term debt	(5,562,553)	(11,519,817)
Purchase of capital assets	(4,752,069)	(8,296,260)
Net cash provided by (used in) capital and related financing activities	(15,656,975)	(26,174,364)
CASH FLOW FROM INVESTING ACTIVITIES		
Change in restricted assets - whose use is limited under bond agreements	4,630,996	(109,040)
Proceeds from sale of short-term investments	347,492	11,656,081
Purchase of short-term investments	4,425,452	(15,824,739)
Investment income received	1,038,082	547,934
Net cash provided by (used in) investing activities	10,442,022	(3,729,764)
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(1,290,576)	14,001,122
CASH AND CASH EQUIVALENTS, BEGINNING OF PERIOD	51,072,795	37,071,673
CASH AND CASH EQUIVALENTS, END OF PERIOD	$ 49,782,218	$ 51,072,795

NORMAN REGIONAL HEALTH SYSTEM
Reconciliation of Net Operating Revenues (Expense) to Net Cash
For The Four Months Ended October 31, 2012

	Unaudited 4 Months FY 2013	Audited 12 months FY 2012
CASH FLOW FROM OPERATING ACTIVITIES		
Operating income plus interest expense	$ 3,776,697	$ 19,050,575
Depreciation and amortization	7,995,206	24,038,751
(Gain)/Loss on disposal of assets	949	(625,192)
Changes in operating assets and liabilities:		
Patient and other accounts receivable, net	5,630,340	(3,966,286)
Supplies and prepaid expenses	(2,964,232)	(1,543,676)
Accounts payable and accrued expenses	(5,836,823)	6,362,460
Estimated amounts due from third-party payers	(3,582,535)	(485,810)
Other assets	(1,095,223)	804,427
Net cash provided by (used in) operating activities	$ 3,924,377	$ 43,635,250

Norman Regional Health System
Cash and Investment Summary
As of October 31, 2012

	Cash	Short-term Investments	Long-term Investments	Total
Balance as of September 30, 2012	**42,748,238**	**5,183,916**	**54,173,620**	**102,105,774**
Receipts	33,875,071	-	-	33,875,071
Disbursements	(26,841,091)	-	-	(26,841,091)
Transfers/Reclassifications	-	-		-
Realized and Unrealized Gains(Losses)/Fees	-	(3,855)	(417,163)	(421,018)
Net Change	7,033,980	(3,855)	(417,163)	6,612,962
Balance as of October 31, 2012	**49,782,218**	**5,180,061**	**53,756,457**	**108,718,736**

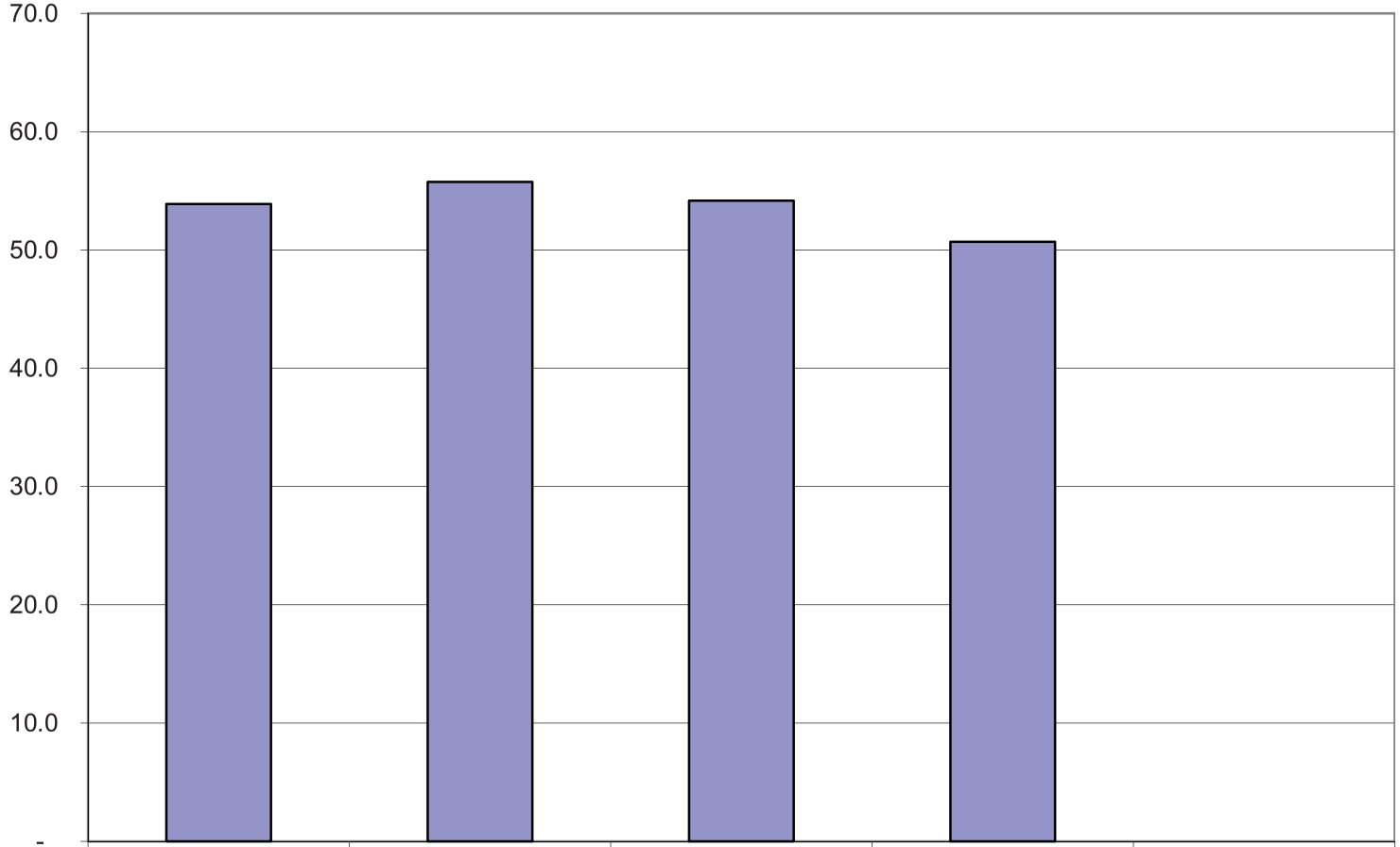
Norman Regional Health System
Consolidated Accounts Receivable Summary
October 2012

	10/31/2012	9/30/2012	Difference
Commercial Ins & Managed Care	$ 32,680,842	$ 33,203,547	$ (522,706)
Blue Cross	19,742,644	20,095,209	(352,565)
Self Pay	29,337,960	28,092,965	1,244,994
Medicare	40,913,021	43,253,549	(2,340,528)
Medicaid	10,508,249	12,421,219	(1,912,970)
HME Services	482,602	527,179	(44,577)
Physician Services	9,041,457	9,146,721	(105,264)
Others	98,348	113,971	(15,623)
Credit Balances included in BD by Fin	667,635	1,347,448	(679,813)
Total Patient Receivable	$ 143,472,758	$ 148,201,810	$ (4,729,052)
Allowance for Bad Debts	$ 35,362,590	$ 34,770,739	$ 591,851
Allowance for Medicare	27,890,561	30,053,178	(2,162,616)
Allowance for Third Party	2,229,856	1,663,068	566,788
Allowance for Blue Cross	8,551,062	9,304,476	(753,415)
Allowance for Medicaid	9,208,170	9,809,883	(601,713)
Allowance for Medical Assistance	33,652	33,652	-
Allowance for Physicians	4,905,064	4,887,772	17,292
Allowance for NRH Employees	1,472,821	1,296,690	176,131
Others	10,384,792	10,952,704	(567,913)
Total Allowances	100,038,568	102,772,163	(2,733,595)
Net Patient Receivables	$ 43,434,190	$ 45,429,647	$ (1,995,457)

Aging of Accounts Receivable (Net of Credit Balances):		% of AR		% of AR	
Inhouse	$ 9,171,263	6.4%	$ 10,475,740	7.1%	$ (1,304,477)
Discharged Not Final Billed	28,859,051	20.2%	26,467,029	18.0%	2,392,022
0 - 30 Days	37,108,937	26.0%	39,757,345	27.1%	(2,648,409)
31 - 60 Days	21,254,653	14.9%	24,013,496	16.4%	(2,758,843)
61 - 90 Days	14,204,413	9.9%	12,775,095	8.7%	1,429,317
91 - 120 Days	10,436,903	7.3%	10,923,193	7.4%	(486,291)
121 - 150 Days	10,111,548	7.1%	10,828,845	7.4%	(717,297)
151 Days & Over	11,658,355	8.2%	11,613,618	7.9%	44,737
Total Patient Receivable	$ 142,805,123	100.0%	$ 146,854,362	100.0%	$ (4,049,239)

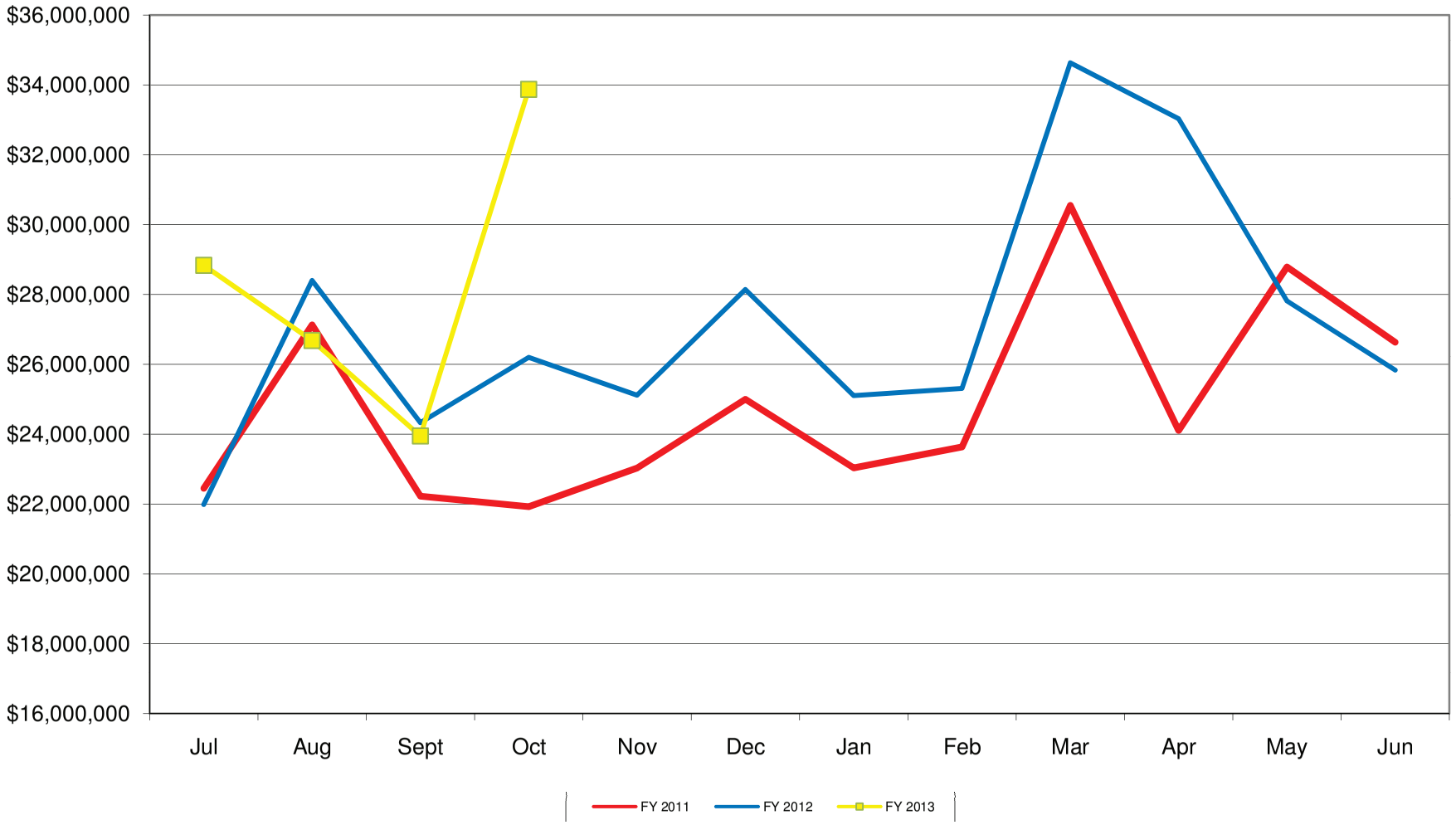
	FYE 6/30/2012	9/30/2012	10/31/2012	Difference
Days net revenue in net A/R	**55.7**	**54.2**	**50.7**	**(3.5)**

Norman Regional Health System
Days Net Revenue in Net A/R



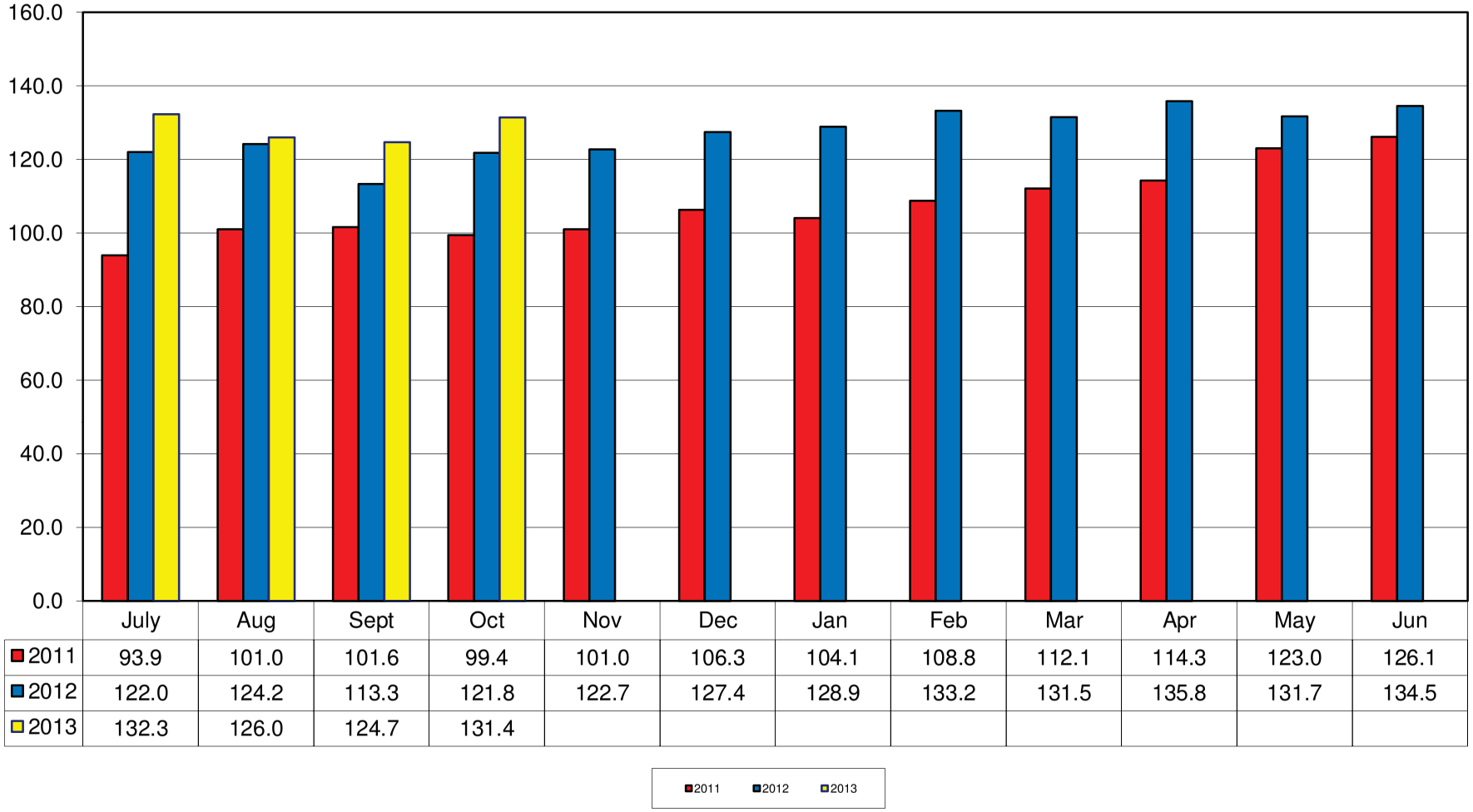
	06/30/2011	06/30/2012	09/30/2012	10/31/2012	
Days Net Revenue in Net A/R	53.9	55.7	54.2	50.7	

NRHS Total Cash Collections by Month FY11-FY13



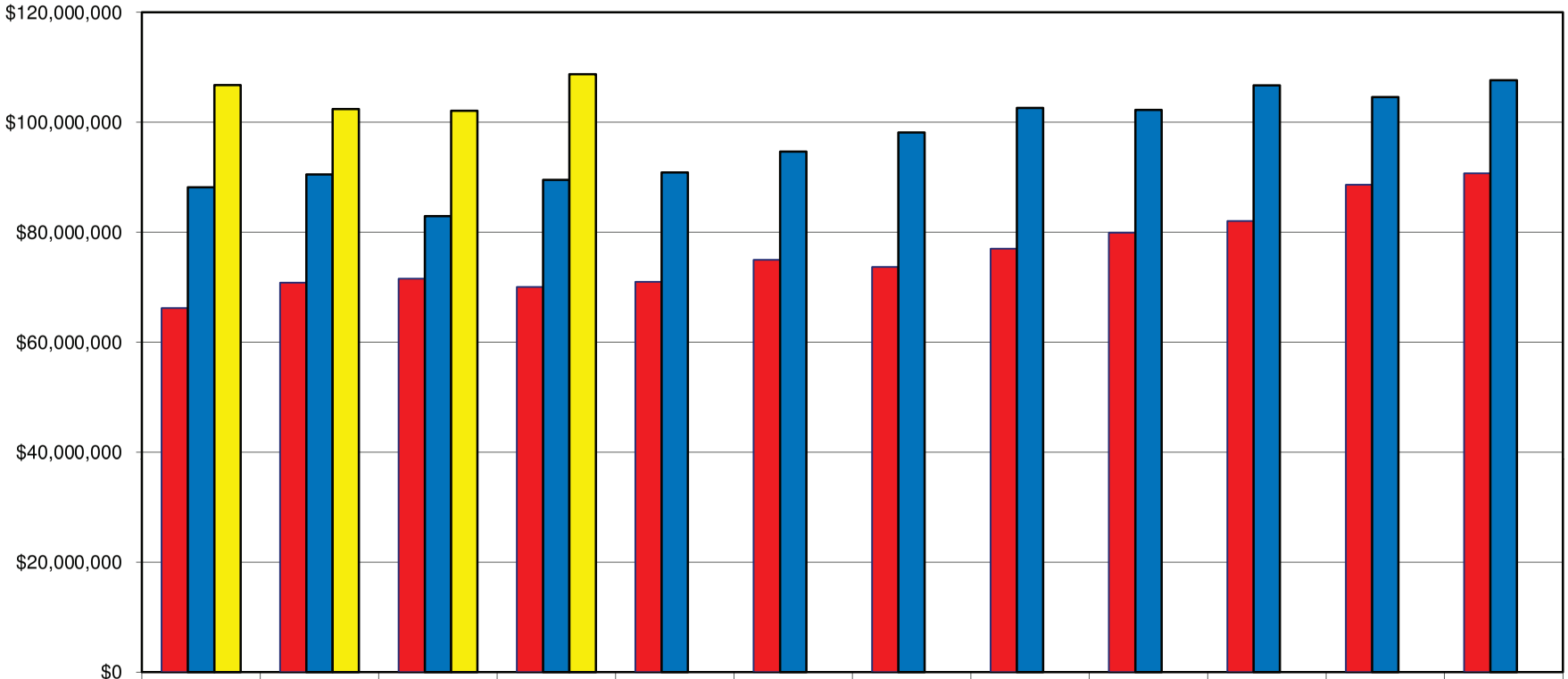
Norman Regional Health System

Days Cash on Hand



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2011	93.9	101.0	101.6	99.4	101.0	106.3	104.1	108.8	112.1	114.3	123.0	126.1
2012	122.0	124.2	113.3	121.8	122.7	127.4	128.9	133.2	131.5	135.8	131.7	134.5
2013	132.3	126.0	124.7	131.4								

Norman Regional Health System
Unrestricted Cash and Investments



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2011	66,216,185	70,807,431	71,539,146	70,059,043	71,003,558	74,996,203	73,698,255	77,032,378	79,923,246	82,054,133	88,648,613	90,724,118
2012	88,156,733	90,534,973	82,948,483	89,542,206	90,867,275	94,652,278	98,125,340	102,623,429	102,269,440	106,700,582	104,577,141	107,651,661
2013	106,756,655	102,418,287	102,105,774	108,718,736								

Norman Regional Health System
Bernstein Investments
Balances As Of Dates Indicated

	As of June 30, 2012	Alloc %	As of September 30, 2012	Alloc %	As of October 31, 2012	Alloc %	FYTD Change in Value	% CHG	Current Month Change in Value	% CHG
Short Term Account	$ 5,159,538	100.0%	$ 5,183,916	100.0%	$ 5,180,061	100.0%	$ 20,523	0.4%	$ (3,855)	-0.1%
Long Term Account										
Cash	$ 374,584	0.7%	$ 620,213	1.1%	$ 430,395	0.8%	$ 55,811	14.9%	$ (189,818)	-30.6%
Bonds	22,299,882	42.9%	20,227,147	37.3%	18,383,481	34.2%	(3,916,401)	(0)	(1,843,666)	-9.1%
US Equities	18,480,682	35.6%	21,297,114	39.3%	22,211,818	41.3%	3,731,136	20.2%	914,704	4.3%
International	4,950,978	9.5%	6,301,593	11.6%	6,699,279	12.5%	1,748,301	35.3%	397,686	6.3%
Emerging Markets	1,829,378	3.5%	2,117,414	3.9%	2,235,369	4.2%	405,991	22.2%	117,955	5.6%
Real Assets	4,039,869	7.8%	3,610,139	6.7%	3,796,115	7.1%	(243,754)	-6.0%	185,976	5.2%
Total Long Term Account	$ 51,975,373	100.0%	$ 54,173,620	100.0%	$ 53,756,457	100.0%	$ 1,781,084	3.4%	$ (417,163)	-0.8%
TOTAL BERNSTEIN	$ 57,134,911		$ 59,357,536		$ 58,936,518		$ 1,801,607	3.2%	$ (421,018)	-0.7%

Allocation of Long Term Account						
Fixed Income	$ 22,674,466	43.6%	$ 20,847,360	38.5%	$ 18,813,876	35.0%
Real Assets	$ 4,039,869	7.8%	$ 3,610,139	6.7%	$ 3,796,115	7.1%
Equity	$ 25,261,038	48.6%	$ 29,716,121	54.9%	$ 31,146,466	57.9%
Total Long Term Account	$ 51,975,373	100.0%	$ 54,173,620	100.0%	$ 53,756,457	100.0%

Norman Regional Health System
Noncurrent Cash and Investments
As of October 31, 2012

Noncurrent Cash and Investments:	
Trustee Held Funds - 1996B Series	
Interest Account	484
Principal Account	200,000
Total Trustee Held Funds - 1996B Series	200,484
Trustee Held Funds - 2002 Series	
Accrued Interest Receivable	0
Interest Account	406,233
Principal Account	216,667
Reserve Account	3,741,050
Total Trustee Held Funds - 2002 Series	4,363,950
Trustee Held Funds - 2005 Series	
Accrued Interest Receivable	0
Project Fund Account	0
Interest Account	601,939
Reserve Account	6,548,999
Total Trustee Held Funds - 2005 Series	7,150,937
Trustee Held Funds - 2007 Series	
Accrued Interest Receivable	0
Project Fund Account	0
Interest Account	738,481
Principal Account	331,239
Reserve Account	7,888,104
Total Trustee Held Funds - 2007 Series	8,957,825
Trustee Held Funds - CD	78,336
Total Noncurrent Cash and Investments	20,751,532

Norman Regional Health System
Long Term Debt
Balances as of 10/31/2012

Description	Outstanding Balance	Interest Rate	Payoff Date
Chase Bank Lease (CT Scanner)	$ 21,097.31	3.7%	12/3/2012
Cath Lab Associates Notes	43,071.46	3.3%	12/1/2012
Bank of America Master Lease	1,433,595.77	4.4%	12/10/2015
Bank of America Master Lease	8,942,683.05	4.4%	3/24/2016
Bonds Payable 1996B Series	15,500,000.00	0.4%	9/1/2022
Bonds Payable 2002 Series	44,725,000.00	4.7%	9/1/2032
Bonds Payable 2005 Series	67,000,000.00	5.5%	9/1/2036
Bonds Payable 2007 Series	86,535,000.00	5.0%	9/1/2037
Total	$ 224,200,447.59		

The 1996B Series Bonds have a variable interest rate. Rate shown is the rate paid for the month reported.

Norman Regional Health System
Uncompensated Care
10/31/2012

	For the month of 10/31/2012	Year to Date as of 10/31/2012
Charity Care (estimated costs)	$ 359,028	$ 2,662,021
Bad Debt (estimated costs)	1,382,351	$ 4,707,893
Community Contributions	161,486	$ 466,629
	$ 1,902,865	$ 7,836,543

Norman Regional Health System
FY 2013 Capital Approvals To Date

2013 Total Capital Budget **$13,500,000**

PO Date	PO Number	Description	Approved PO's	Total Cost
7/10/2012	156372	VS Monitor	$3,032	$3,032
7/10/2012	156924	Conmed Replacement Lap Instruments	$81,308	$81,308
8/15/2012	160065	Nurse Phones	$12,373	$12,373
8/20/2012	160758	Double Door Refrigerator 40 cu ft.	$4,575	$4,575
8/20/2012	160759	General Purpose Refrigerator	$3,550	$3,550
8/20/2012		Infiniti Vision System		$45,500
8/27/2012	161601	Broselow Cart System	$2,916	$2,916
8/27/2012	161896	Flooring Replacement for 3 South	$6,860	$6,860
8/27/2012		Surgery Waiting Room Cost (hospital's share)		$135,285
8/27/2012	160757	Wiring and Computer Drops	$12,574	$12,574
8/27/2012		Ambulance		$89,625
9/17/2012	163502	Sealing and Restriping Parking Lots	$20,880	$20,880
9/17/2012	163506	Replacement PACS Monitors	$8,870	$8,870
9/17/2012	163512	Replacement PC's for Radiologists	$8,285	$8,285
9/19/2012	163612/163614	MMC Access Controls	$15,458	$16,958
9/24/2012	164726	RML Interface for Lab	$5,243	$5,243
10/1/2012	164235/164329	Suction	$10,358	$10,358
10/4/2012	165230	2012 Toyota Prius	$23,800	$23,800
10/11/2012	165912	Pediatric Cystoscope	$14,445	$14,445
10/15/2012	166188	Meditech Custom Software	$5,000	$5,000
10/15/2012	165455	Patient Monitor	$5,158	$5,158

TOTAL APPROVED	**$516,595**
REMAINING BALANCE	**$12,983,405**

BE=budgeted equipment

BI=building improvement

UE=unbudgeted equipment

UB=unbudgeted building improvement

Proposed Medical Staff Bylaws Revisions

3.13 "Department" shall mean the delineated practice areas designated by the Medical Staff from time to time. Current Departments include Anesthesia, Behavioral Medicine, Cardiovascular Medicine, Emergency Medicine, ~~Family Medicine~~, Hospital Medicine, Medicine, OB/Gyn, Pathology, Pediatrics, Radiology and Surgery.

5.6 Participants in ~~Professional Graduate Education Programs~~*Healthcare Student or Resident Proctorship*

5.6.1. Participants in ~~professional graduate education programs~~ ***Healthcare Student or Resident Proctorship*** assigned by their school to members of the Medical Staff as preceptors, may participate directly in the management of patient care while under the supervision and direction of their preceptor (i) only to the extent permitted under Oklahoma law and (ii) only so long as the preceptor is a Medical Staff Member who is a qualified licensed independent Practitioner and has unsupervised and unrestricted clinical privileges at the Hospitals. ***Healthcare Students or Residents will abide by all System and Medical Staff Policies, Bylaws, and Rules & Regulations.***

~~5.6.2 A professional graduate education ("PGE") program participant must submit to the System (i) evidence of professional liability insurance coverage; (ii) a letter from the chairperson of his/her PGE program indicating that such participant is a member in good standing of the relevant program; (iii) a letter from the participant's Medical Staff preceptor containing a commitment to supervise such PGE program participant, and (iv) any additional items deemed necessary by the System. PGE program participants shall only be assigned as permitted by the agreement between the System and the applicable PGE programs. The Resident Job Description contains more specific information regarding permissible patient care activities for different categories of PGE participants, limitations on chart entry and order writing, and other related matters.~~

15.1 Organization of Departments. Current Departments include Anesthesia, Behavioral Medicine, Cardiovascular Medicine, Emergency Medicine, ~~Family Medicine~~, Hospital Medicine, Medicine, OB/Gyn, Pathology, Pediatrics, Radiology and Surgery. Each Department shall be directed by a Department Chair and shall function under the Medical Executive Committee.

16.3.1 Composition. The Practitioner Performance Improvement Committee ("PPIC") shall be comprised of seven (7) Members of the Medical Staff including one member from each of the following Departments: Medicine, ~~Family Medicine~~, Pediatrics, OB/Gyn and Surgery. Also, two (2) at-large members from other Departments will be members of the committee. The Director of performance Improvement will be a non-voting member of the Committee, and will be allowed to attend executive sessions of the committee meetings with permission by the Medical Staff Members of the PPIC. A member of the Governing Body will be invited to attend all meetings of the PPIC.

NORMAN REGIONAL HEALTH SYSTEM
PRIVILEGE REQUEST FORM

Emergency Medicine

To be eligible to request clinical privileges for **Emergency Medicine**, a practitioner must meet the following minimum threshold criteria:

Education: MD or DO

Minimal formal training: Successful completion of an ACGME or AOA accredited residency training program in Emergency Medicine or Family Medicine. ~~with Emergency Medicine attending supervision~~. Current ACLS, ATLS and PALS certification are desirable.

Board Certification: The applicant must be Board Certified in Emergency Medicine or successfully achieve ABMS or American Osteopathic Board Certification within 5 years of completion of residency. The applicant may be board certified or board eligible in Family Medicine but, if working in the Emergency Department, must be ~~directly~~ supervised by an Emergency Medicine attending.

Required previous experience: Applicants must be able to demonstrate that they have provided emergency medicine services to at least 100 patients in the past 12 months.

References: A letter of reference must come from the director of the applicant's emergency medicine training program. Alternatively, a letter of reference regarding competence should come from the Chief of Emergency Medicine at the institution where the applicant most recently practiced.

Privileges may only be exercised in a setting that has the appropriate equipment, license, beds, staff and other support required to provide the services defined in this document.

Core privileges: **If you meet the above criteria, you may request core privileges as specified below. Place line through individual core privileges not requested.**

I understand that, if residency trained and Board Certified or Board Eligible in Family Medicine, I must be ~~directly~~ supervised by an Emergency Medicine attending when I work in the Emergency Department.

_____ **I hereby request Core Emergency Medicine Privileges as follows:** Emergency medicine physicians assess, evaluate, diagnose and initially treat patients of all ages who present in the Emergency Department with any symptom, illness, injury, or condition, and provide services necessary to ameliorate minor illnesses or injuries. In addition, they stabilize patients with major illnesses or injuries and assess all patients to determine whether additional care is necessary. Core privileges may include privileges to admit for inpatient care in consultation with a treating physician or hospitalist if bylaws allow. Privileges do not include long-term care of patients on an inpatient basis. Core privileges do not include privileges to perform scheduled elective procedures, with the exception of procedures performed during routine ER follow-up visits. Core privileges may include privileges to admit to an observation unit if hospital bylaws allow. The following privileges are included in the core:

- minimal sedation/analgesia (anxiolysis)
- moderate sedation/analgesia (conscious sedation)

FAMILY MEDICINE FELLOWSHIP IN EMERGENCY MEDICINE

INTRODUCTION

The participating fellow will be supervised at all times by an emergency medicine Board Certified/Board Eligible physician. Supervision shall mean that the attending Board Certified/Board Eligible emergency medicine physician will be present in the emergency department and directly/indirectly supervising the care of each patient seen by the fellow. Each patient evaluated by the fellow will also be seen by the attending physician. The attending physician is ultimately responsible for all aspects of patient care.

PROCEDURES

The attending emergency physician shall directly supervise all procedures early on in the fellowship. The fellow will keep procedure logs. Additionally, the fellow will have a procedure competency card signed by the attending physician for each procedure performed early on in the training process. Once the fellow has been deemed competent for a specific procedure, indirect supervision will be allowed. Specific procedure numbers required for competency will vary from fellow to fellow and will ultimately be determined by the program director and emergency department attending physicians.

DIRECT SUPERVISION

The emergency medicine Board Certified/Board Eligible physician is physically present at the bedside with the fellow and patient.

INDIRECT SUPERVISION

The emergency medicine Board Certified/Board Eligible physician is physically present in the emergency department and immediately available to provide direct supervision.

FEEDBACK

The attending physician will provide feedback to the fellow in the form of completed procedure evaluation cards as well as clinical evaluation cards.

Norman Regional Health System
Capital Equipment Over $25,000

Item	Vendor	Department	Budget	Bid Results	PO Cost
(3) EKG Stress Treadmills	GE	Norman Heart and Vascular		$88,439	$88,439
Total			**$0**	**$88,439**	**$88,439**

Robin Wiens Campbell Date
Chairman of the Board

Jeffrey Burcham, OD Date
Chairman, Finance Committee

Norman Regional
HEALTH SYSTEM

Capital Equipment Justification

Description of Item or Project and Its Purpose

Purchase of 3 stress systems (treadmill, EKG, BP, storage to MUSE-EKG system) 3 are needed for the operations at the new Heart Plaza. Request is submitted now, because one of the cardiologist's clinics (Dr. Salim) is in desperate need of a replacement system now. We will hold off on delivery of the other two until the Heart Plaza is ready.

Needs Statement

According to Cathy Kravick, the system at Dr. Salim's office is in need of replacing. Very poor quality studies. Both doctors are very unhappy with the results. Very hard for the technicians to use the equipment and get a decent study.

How many do we currently have? 1 at each cardiologists office, 1 HPX Hospital, 2 at Porter

If applicable, how many times a year is this piece of equipment used? Most week days in clinic.

What other (if any) alternatives have been considered?

Continue to use current system in clinic, knowing its current condition and possible misdiagnosis for ekg tracings during stress procedure.

Existing systems at hospital are in use and cannot be transferred to clinic.

Corporate Compliance Annual Report
FY2012

A. Introduction to, and Overview of, Norman Regional Health System's Compliance Program

Healthcare compliance programs date back to the mid-1990s and have consistently grown in scope and importance. The federal government continues to be increasingly aggressive in its pursuit of healthcare fraud and abuse. The 2010 passage of the Patient Protection and Affordable Care Act will make compliance programs mandatory once the Secretary of the Department of Health and Human Services promulgates core elements and sets an effective date.

To emphasize the importance of compliance programs, as well as to assist hospitals in their compliance efforts, the Office of the Inspector General ("OIG") has twice published guidance for hospitals. Compliance is an active, on-going process that is everyone's responsibility, and according to the *Compliance Program Guidance for Hospitals*, Compliance Programs should, at a minimum, include seven components (See Tab A). Items C through I of this report list the Seven Essential Elements of Effective Compliance Programs and illustrate the manner in which NRHS's Compliance Program achieves each.

Other primary compliance enforcement entities are the Department of Justice, including the FBI, Centers for Medicare & Medicaid Services ("CMS"), state Medicaid fraud units, the Office for Civil Rights, and the Federal Trade Commission ("FTC"). Private payers and *qui tam* relators, or whistleblowers, are additional factors in the compliance arena. Additionally, HIPAA regulations are enforced by the Department of Health and Human Services Office for Civil Rights ("HHS/OCR").

There continue to be numerous agencies regulating hospitals (See Tab B), a multitude of statutes and regulations that apply to healthcare organizations participating in federal health programs (See Tab C), and there are risks unique to healthcare providers (See Tab D). But despite the government's efforts, health care fraud and abuse is a growing problem, and those issues are a top government priority.

During the first half of federal FY2012, OIG reported:

- Expected recoveries of approximately $1.2 billion consisting of $483.1 million in audit receivables and $748 million in investigative receivables.
- Exclusions of 1,264 individuals and entities from participation in federal health care programs;
- 388 criminal actions against individuals or entities that engaged in crimes against HHS programs; and
- 164 civil actions including false claims, civil monetary penalties settlements, and administrative recoveries related to provider self-disclosure matters.

The following examples of recent fraud and abuse illustrate the government's aggressive adjudication in recent healthcare fraud cases that run the gamut from individuals to health systems:

- An eight-city sweep by the Medicare Fraud Strike Force netted 91 suspects – including 11 physicians and two nurses – for various fraud schemes involving false billing. The $295 million in false Medicare billings represents the largest single amount of fraud uncovered in a single investigation in the four-year history of the Strike Force. More than 400 investigators from the Department of Justice, FBI, Office of the Inspector General, and state and local law enforcement agencies took part in the raids, federal authorities said in a joint media release.

- The former chief executive officer and owner of Chicago's now closed Edgewater Hospital and Medical Center and his lawyer were indicted for allegedly lying and obstructing justice in the government and a bank's efforts to collect $188 million involving fraud. The CEO and his wife allegedly received millions from an offshore trust. Peter G. Rogan and attorney Frederick M. Cuppy were each charged with one count of conspiracy to obstruct justice. Cuppy also was charged with three counts of perjury and three counts of obstruction of justice.

- Houston doctor Christina Joy Clardy has been sentenced to 135 months in federal prison for her role in a massive health care fraud conspiracy that billed the federal Medicare and Texas Medicaid programs for $45,039,230 over a 2.5-year-period. Clardy is the third defendant to be sentenced in this matter. Clardy, who was found guilty of one count of conspiracy to commit health care fraud, 14 counts of health care fraud and three counts of mail fraud, was also ordered to pay $15,626,084.01 in restitution to Medicare and Medicaid. In arriving at Clardy's sentence today, Judge Harmon considered the pivotal role Clardy played in abusing the trust of the Medicare and Medicaid programs by allowing the fraudulent billing under her provider numbers.

- A Georgia grand jury returned indictments against an Atlanta OB-GYN and two former members of his clinic staff. Nathaniel Johnson, III, Jeff Romeus and Jasmin Tunica-El were each charged with one count of Medicaid fraud and one count of conspiracy to defraud the state. Johnson and Romeus were also charged with practicing medicine without a license.The charges allege that between 2004 and 2008, Johnson, Romeus and Tunica-El fraudulently billed Medicaid using Johnson's provider number for more services than were provided and for services that were not rendered. The charges also allege that Johnson knowingly permitted Romeus to practice medicine at Regency between 2005 and 2008 without a valid license under Georgia law.

- Christus Spohn Health System Corp. paid $5 million to settle allegations it violated the False Claims Act. The health system fraudulently reported inpatient codes for services it should have reported with outpatient codes and consequently received higher reimbursement than it should have. The settlement involves six of the health system's hospitals.

- Tenet Healthcare Corporation agreed to pay $42.75 million to settle false claims allegations stemming from the company's inpatient rehabilitation billing practices. Court documents indicate that between May 2004 and December 2007, Tenet billed Medicare for services rendered to patients treated in Tenet's inpatient rehabilitation facilities across the country who did not meet the medical necessity requirements outlined for intensive rehabilitation programs. The settlement constitutes the single largest recovery of improper payments to an inpatient rehabilitation facility.

During FY2012, HHS/OCR received over 9,810 HIPAA Privacy complaints. Of those, over 2,735 were investigated and resolved by requiring corrective action. No violation was found in over 1,273 of the complaints. And over 4,924 were not eligible for enforcement.

HHS/OCR referred a total of nine cases to the Department of Justice for criminal investigation. At the end of FY2012, the top five issues in investigated cases were:

- Impermissible uses and disclosures of Protected Health Information ("PHI");
- Lack of safeguards of PHI;
- Lack of patient access to their PHI;
- Uses or disclosures of more than the minimum necessary PHI; and
- Lack of administrative safeguards of electronic PHI.

B. The Accountability of Health Care Boards

Increasingly, directors are being held responsible for the entities whose boards on which they sit. The OIG and the American Health Lawyers Association have issued an educational publication, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors* (See Tab E) to provide guidance to members of those governance bodies.

C. Element One: Standards of Conduct and Written Policies and Procedures that Promote a Commitment to Compliance

Crowe & Dunlevy, PC, reviews and updates the NRHS Compliance Program ("Program") annually. The Board approved the 2011 update on September 26, 2011, and the 2012 revision is underway.

Every updated version of the Program is distributed to leadership staff and the Authority. It is also available for every new and current employee, as well as contract staff.

The Code of Conduct is revised every three years, or, if needed, more often. The most recent revision was in November 2011. Every employee received a copy of the Code, and new employees are given copies during orientation.

It is NRHS's policy to provide services in compliance with all applicable federal, state and local laws. In its current form, the Compliance Program promotes an organizational culture that encourages ethical behavior, commits to compliance with the law, provides a guide for the conduct of employees, et al, and prevents and detects violations of law and criminal conduct.

With one exception, NRHS's Compliance and HIPAA policies are reviewed and, if necessary, revised biannually. The "Identity Theft: Red Flag Rules" HIPAA policy is reviewed/revised annually.

D. Element Two: Regular, Effective Education and Training Programs

Education and training can be considered the first line of defense in a Compliance Program, and because they are so vital to compliance in general, and NRHS's Compliance Program specifically, we primarily concentrate our effort in this area every year. This emphasis continually results in an increase in the awareness of potential and real compliance issues among hospital staff, and FY2012 was no exception. The year's education and training included:

New Employee Education:
New employees received Compliance and HIPAA education during orientation and passed a post-test. New employee education is updated annually.

Mandatory Education Requirement:
One hour of Compliance and HIPAA education is required of all Board members, employees, employed physicians, students, volunteers and contractors. Education

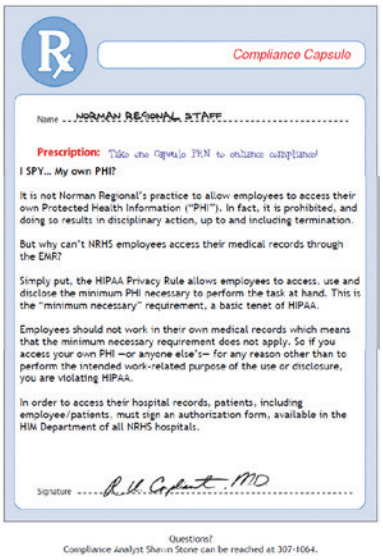
requirements are tracked by the calendar year, and for CY2011:

- The Board received the annual education program on DVD and achieved 100% compliance; that is also the goal for CY2012.
- Employees, employed physicians, and contract staff utilized the three-part online education module on Compliance, HIPAA Privacy and HIPAA Security via online HealthStream Learning Center ("HLC") modules.
- A Compliance/HIPAA training video and live presentations were available for volunteers and students.
- Compliance and HIPAA education requirements are tracked via HLC, and 100% compliance was achieved.

All education presentations, regardless of format, are updated annually.

Coder-specific Mandatory Education Requirement: All medical coders are required to complete eight hours of continuing education each calendar year. This requirement was met in CY2011.

Compliance Capsules: The Compliance Analyst writes Compliance Capsules (See Tab F), a creative education tool that delivers education on a variety of compliance and HIPAA topics.



Compliance Capsule

Name ... NORMAN REGIONAL STAFF ...

Prescription: Take one Capsule PRN to enhance compliance!

I SPY... My own PHI?

It is not Norman Regional's practice to allow employees to access their own Protected Health Information ("PHI"). In fact, it is prohibited, and doing so results in disciplinary action, up to and including termination.

But why can't NRHS employees access their medical records through the EMR?

Simply put, the HIPAA Privacy Rule allows employees to access, use and disclose the minimum PHI necessary to perform the task at hand. This is the "minimum necessary" requirement, a basic tenet of HIPAA.

Employees should not work in their own medical records which means that the minimum necessary requirement does not apply. So if you access your own PHI –or anyone else's– for any reason other than to perform the intended work-related purpose of the use or disclosure, you are violating HIPAA.

In order to access their hospital records, patients, including employee/patients, must sign an authorization form, available in the HIM Department of all NRHS hospitals.

Signature ..... R.U. Compliant, MD .....

Questions?
Compliance Analyst Shawn Stone can be reached at 307-1064.

Compliance Capsules are distributed via email by the fictitious Dr. R.U. Compliant semi-monthly.

Additional Education Opportunities:

- In an ongoing effort to increase staff compliance awareness, answer their questions, address any concerns, and provide education, periodic rounds were made throughout the Health System by the Compliance/Privacy Officer, Compliance Analyst and Risk Management staff.
- Upon request, Compliance staff attends department meetings and provides education on specific topics. The Compliance Analyst attended and provided education at 24 department meetings for Dist/Trans, EVS, Laboratory, Women's & Children's Health, Nursery, Security, MMC Respiratory Therapy, Imaging Services, Laboratory clerks and Surgical Services.
- In September 2011, a "Compliance Carnival" came to town to mark 2011 NRHS Compliance Week, the theme of which was "Making Excellence a Habit."

Compliance Committee members hosted carnival games at the three hospitals, and scores of employees participated for free cookies. Additionally, a paper-only scavenger hunt (See Tab G) was held, and a basketball goal was given away to one of those 332 participants.

- HIPAA Privacy & Security Week was celebrated in May 2012, which gave Compliance staff and members of the HIPAA Committee an opportunity to provide additional education. The week's theme was "I SPY: The Importance of Security & Privacy to You." A total of 213 completed the "I SPY and Find" puzzle (See Tab G), and countless employees visited the HP&S Week table in the three hospital cafeterias and enjoyed daily Compliance Capsules.

E. Element Three: Designation of a Chief Compliance Officer and of a Corporate Compliance Committee

NRHS Compliance Officer:

Legal & Regulatory Services Director Sharon Parker remains as Compliance Officer and continues to coordinate and monitor compliance activities within the Health System.

In 2002, Sharon Parker was appointed Privacy Officer and implemented the HIPAA Privacy Rules by the April 2003 deadline; she continues in that position.

Shawn Stone is the Compliance Analyst, a position she has held since October 2005. She is certified in healthcare compliance and became certified in healthcare privacy compliance in 2011.

NRHS Compliance Committee:

The Compliance Committee was established in 1999 and meets on a quarterly basis. In addition to advising the Compliance Officer, the Committee's duties include assessing

existing policies and procedures relating to compliance concerns, assessing the Health System's mechanisms for promoting compliance, and working with NRHS departments to promote compliance.

The Committee consists of the Compliance Officer, Compliance Analyst, Internal Auditor and RAC Coordinator. Other members include NRHS directors, managers and supervisors from various areas including: Emergency Services, Finance, Human Resources, Health Information Technology, Patient Financial Services/Health Information Management, Laboratory, Patient Care Services, Case Management, Health Promotion Services, Patient Access, Payer Contracting & Revenue Integrity, Business Development, Diagnostic Imaging and Pharmacy.

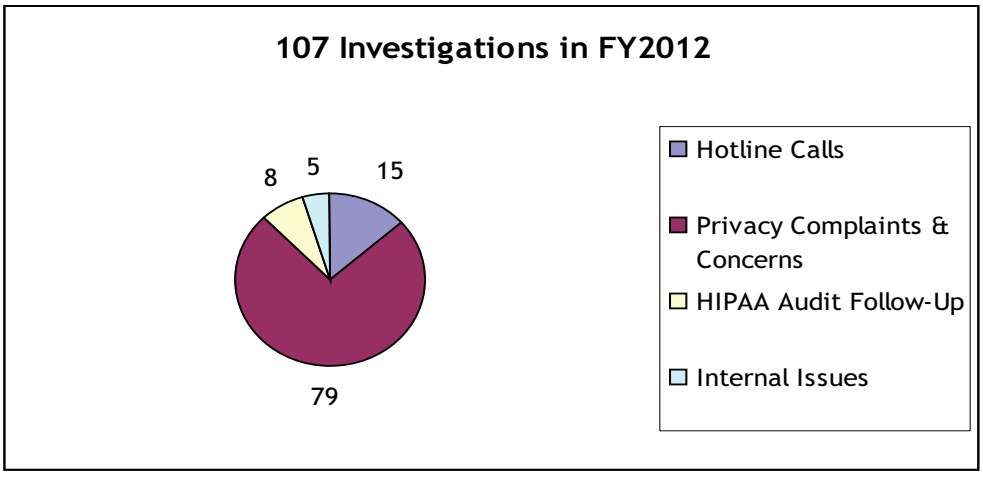
F. Element Four: Effective Lines of Communication

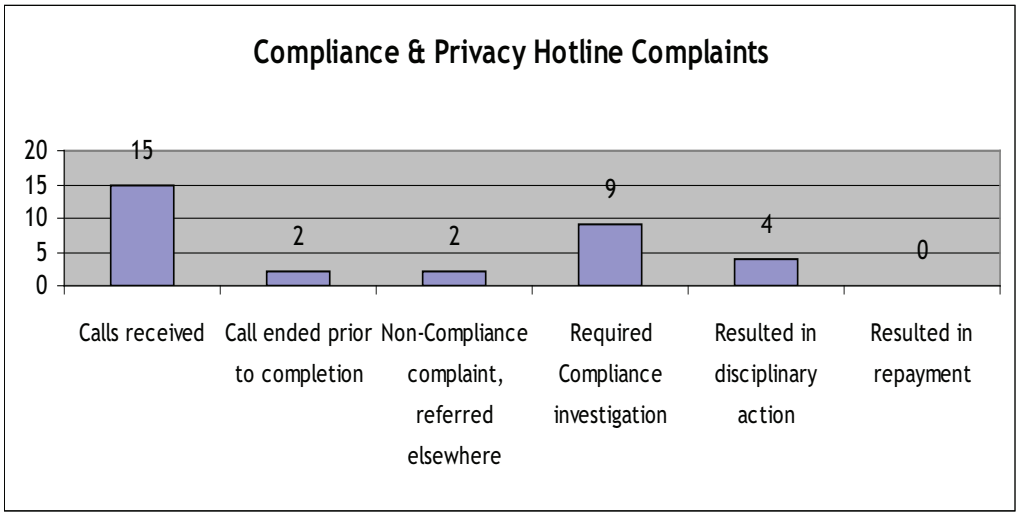
Compliance staff strive to effectively communicate with all levels of personnel in an effort to promote the NRHS Compliance Program and to reduce any potential waste, fraud, and abuse. Several factors are fundamental to our communication efforts: 1) accessibility; 2) the policy of zero tolerance for retaliation; and 3) the knowledge that all Compliance concerns are fully investigated.

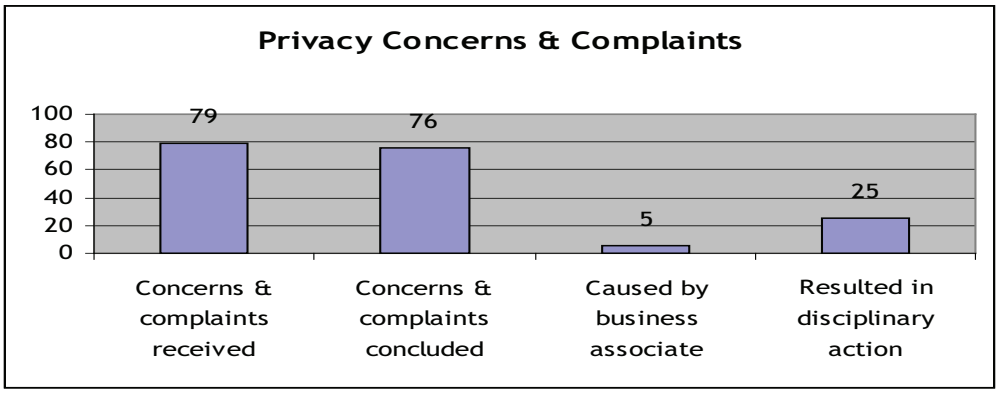
NRHS's Compliance & Privacy Hotline continues to be a major component of this effort. Historically, the bulk of the concerns (i.e., privacy complaints and concerns and internal issues) come to Compliance by other means such as via telephone calls and face-to-face contact, positively indicating that employees perceive the Compliance staff as being open and willing to address their concerns appropriately.

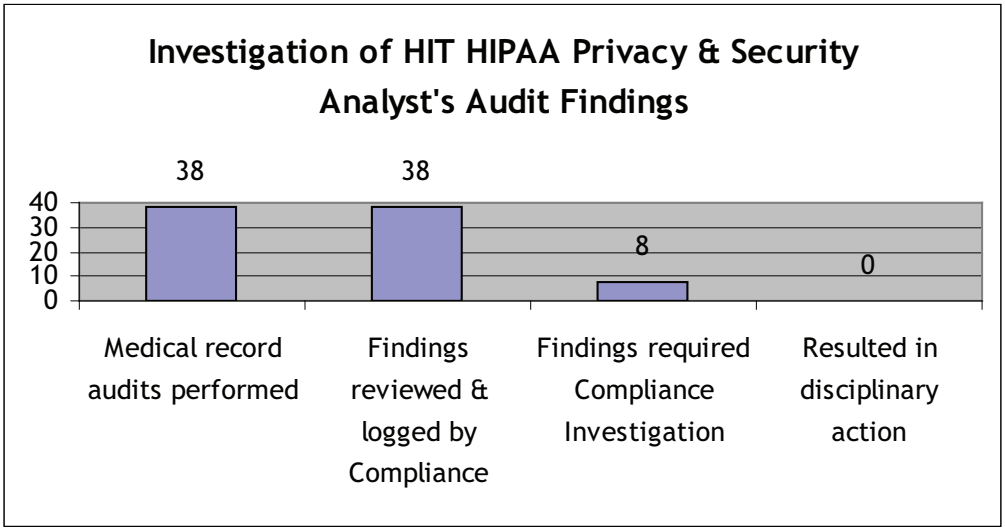
Compliance staff also looked into a number of Privacy audit findings with the HIT HIPAA Privacy & Security Analyst, a new position established earlier this year.

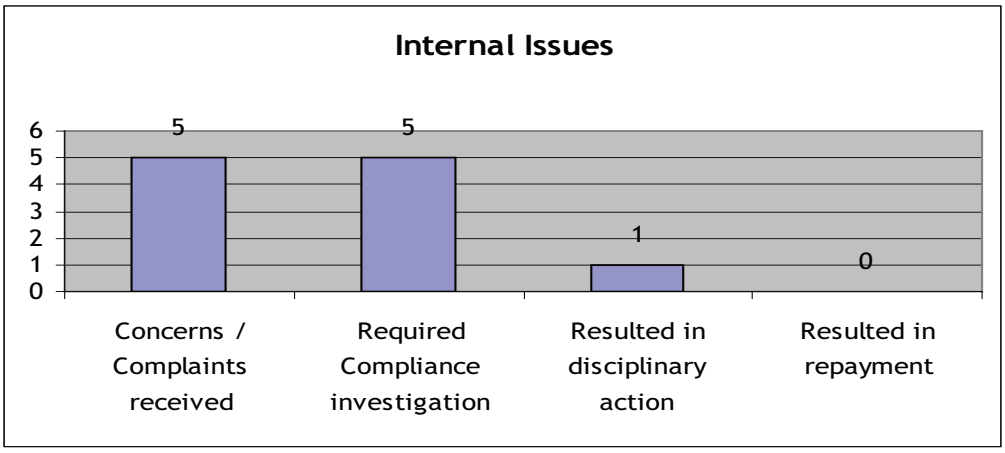
A total of 107 concerns, complaints and issues were brought to Compliance staff in FY2012:




Compliance & Privacy Hotline Complaints
20
15
10
5
0
15
2
2
9
4
0
Calls received
Call ended prior to completion
Non-Compliance complaint, referred elsewhere
Required Compliance investigation
Resulted in disciplinary action
Resulted in repayment


Privacy Concerns & Complaints
100
80
60
40
20
0
79
76
5
25
Concerns & complaints received
Concerns & complaints concluded
Caused by business associate
Resulted in disciplinary action


Investigation of HIT HIPAA Privacy & Security Analyst's Audit Findings
40
30
20
10
0
38
38
8
0
Medical record audits performed
Findings reviewed & logged by Compliance
Findings required Compliance Investigation
Resulted in disciplinary action



G. Element Five: Enforcement of Standards through Well-Publicized Disciplinary Guideline

Compliance staff investigated all Compliance-related complaints, hotline calls, concerns and issues fully and expediently, appropriately taking corrective action when indicated by investigation; when warranted, disciplinary action was taken.

H. Element Six: Auditing and Monitoring

Compliance staff strive to continually improve compliance activities, and the OIG emphasizes the importance of evaluation. The process includes several aspects of monitoring and auditing, including reviewing the OIG Work Plan following its annual release each autumn. The Work Plan describes various projects, including areas of high risk for fraud and abuse, which the OIG plans to continue or initiate in its fiscal year. FY2012's auditing and monitoring efforts included:

Monitoring of OIG issuances: The OIG publishes several types of issuances, including advisory opinions, open letters, safe harbor regulations, fraud alerts, bulletins, compliance resource material and compliance and other guidance. The Compliance Analyst monitors the OIG's issuances monthly. The OIG issued a number of documents during FY2012.

FY2012 OIG Issuances:

	July	August	September	October	November	December	January	February	March	April	May	June
Advisory Opinions	4	2	2	1	3	1	-	-	2	3	1	2
Other Guidance	-	-	-	-	-	-	-	1	-	-	-	-

Monitoring of exclusions screenings: In accordance with the OIG, all current employees and, for one year following termination, all termed employees are screened against two federal databases in an effort to verify that no NRHS staff have been excluded from participating in federal health care programs and, as a result, cannot receive payment from those programs. Staff lists are compared to the OIG's List of Excluded Individuals/Entities and the General Services Administration's Excluded Parties List System on a regular basis.

Based on an April 2009 Oklahoma Health Care Authority ("OHCA") letter to Medicaid providers in which OHCA recommended that, as a condition of continued participation in the Medicaid programs, providers perform monthly searches on the OIG's website "to capture exclusions and reinstatements of individuals or entities," NRHS contracted with John Sterling Associates in July of that year to perform: 1) a comprehensive annual screening of all Health System practitioners, current employees, and those whose employment was terminated within one year via both the OIG and GSA databases; and 2) a monthly screening of the above parties, plus all new employees, via the OIG database (the Compliance Analyst compares new employees' names to the GSA database).

Exclusions Screenings Performed During FY2012:

Annual Screening of Employees & Practitioners (August 2011):

Group:	Total screened:	# of same name matches:	# of excluded individuals:
Employees	3,435	252	0
Practitioners	370	28	0

Monthly Screening of New Employees (September 2011 – July 2012):

Month:	New employees screened:	Termed new employees screened:	# of new employees screened:	# of same name matches:	# of excluded individuals:
September 2011	56	0	56	1	0
October 2011	60	2	62	1	0
November 2011	30	0	30	1	0
December 2011	41	1	42	1	0
January 2012	38	0	38	0	0
February 2012	33	3	36	0	0
March 2012	71	2	73	5	0
April 2012	50	0	50	2	0
May 2012	37	0	37	1	0
June 2012	41	2	43	1	1*
July 2012	33	1	34	1	1*

* Former employees were excluded after separating from NRHS

Monitoring of vendor gifts: Monthly compliance with the Board-mandated *Gifts from Vendors* policy (CC9512-015) is continually monitored by the Compliance Analyst.

Vendor Gift Log Filing by Departments in FY2012

Month:	Reported timely*:	Reported late:	Not reported**:
July 2011	74%	26%	0%
August 2011	86%	14%	0%
September 2011	70%	30%	0%
October 2011	97%	3%	0%
November 2011	84%	16%	0%
December 2011	77%	23%	0%
January 2012	78%	22%	0%
February 2012	71%	28%	1%
March 2012	81%	18%	1%
April 2012	77%	22%	1%
May 2012	77%	23%	0%
June 2012	83%	17%	0%

***** An average of 68, or 44%, of departments do no accept gifts from vendors

****** A concentrated effort in CY2011 and CY2012 to obtain 100% compliance in filing the monthly logs has resulted in great improvement from an average of 69% of logs filed from CY2007 through CY2010 to 98% in CY2011 and 99.5% over the first half of CY2012.

Vendor Gifts Received During FY2012

Month:	# of gifts received:	# of dept. gifts received:	# of individual gifts received:	Total value of gifts received:
July 2011	126	4	122	$1,638.99
August 2011	135	3	132	$1,535.29
September 2011	76	12	64	$2,201.04
October 2011	109	23	86	$3,942.93
November 2011	52	6	46	$1,096.09
December 2011	105	32	73	$3,073.77
January 2012	42	39	3*	$4,130.38
February 2012	47	46	1	$5,361.31
March 2012	45	44	1	$4,788.19
April 2012	37	37	0	$3,705.11
May 2012	37	37	0	$4,076.88
June 2012	44	41	3	$4,877.26
Totals:	855	143	1349	$29,612.41

***** Effective 1/1/12, gifts such as lunches that are provided for all present department staff are considered to be one department gift and are tracked and reported as such.

ICD Registry*:* In compliance with CMS's 2005 mandate for participation in a repository

of information for all hospitals nationwide that are performing implantable cardioverter defibrillator ("ICD") procedures, Compliance staff enters implant information for every ICD recipient who is also a Medicare beneficiary.
A total of 23 accounts, with total charges of $2,884,424.03, were added to the ICD Registry this fiscal year.

NRHS Compliance Audit Revenue Team ("CART"):

- Recovery Audit Program:
  - *Complex Reviews*: The RAC Coordinator received four medical record requests, totaling 485 records, for the purpose of complex reviews:

FY2012 Recovery Audit Program **Complex Reviews**

Request Date	Records Reviewed	Approved	Adjusted	Deselected	Reviews not Completed	Amounts Recovered
7/27/11	16	8	8	0	0	$35,192.92
12/21/11	10	5	5	0	0	$74,316.21
4/4/12	230	22	29	0	179	$236,745.10
5/22/12	229	0	0	0	229	$14,423.71
Totals	485	35	42	0	408	$346,254.23

  - *RAC Automated Reviews Total*: $30,719.12

	Review Types						
	Recovery Audit Program	Medicare Prepayment Reviews	Medicare Advantage	Medicaid Retro Reviews	OKla. Foundation for Medical Quality	Comprehensive Error Rate Test	Totals
Audit Requests	**485**	**99**	**218**	**1,246**	**9**	**14**	**2,071**
	$3,066,799	**$865,921**	**$1,214,422**		**$124,798**	**$63.342**	**$5,335,282**
Upheld	155	29	6				190
	$1,311,400	$264,636	$40,352				$1,616,388
Denied	**330**	**64**	**16**	**2**	**2**	**3**	**417**
	$1,755,399	**$548,804**	**$51,619**	**$5,859**	**$8,348**	**$26,861**	**$2,396,889**
Recoveries	243		6		2	1	252
	$1,395,790		$30,244		$8,348	$3,232	$1,437,615
In Appeal	**236**	**62**	**15**		**0**	**2**	**315**
	$1,326,709	**$534,955**	**$54,919**			**$16,455**	**$1,933,038**
Overturned Appeals	0	4	1		1		6
	$0	$44,701	$3,003		$5,521	$	$53,225

Audit activities:

- Audit performed by external auditors:
  - As previously reported to the Board, BKD, an independent audit firm,

performed a financial audit for fiscal year end 6/30/2012 and issued an unqualified opinion. The report is dated September 24, 2012.

- Audits completed in FY2012 by Legal & Regulatory Services staff:
  - The Compliance Analyst completed an audit to determine: (a) whether the vendor of the Compliance & Privacy Hotline complies with their timeframe to notify Compliance of hotline calls (they do); and (b) how accurate their call reports to NRHS and the responses to complainants are (they are read verbatim).
  - The Compliance Analyst also completed an audit of staff utilization of the Quantim Correspondence Management tool to determine whether hospital staff properly utilizes Quantim disclosure-tracking software to notate disclosures of patient PHI; she found that department staff either use the tool appropriately or send requestors to HealthPort ROI staff for release and tracking.
  - The Big Audit, the goal of which was to compile a comprehensive listing of all auditing, monitoring, reviewing and tracking performed by, for and within all areas of the NRHS for future reference in the event the information is ever requested by any government investigator(s). Information is currently being catalogued by the Compliance Analyst.
  - The Risk Management Analyst completed the annual EMTALA Audit.
  - The Risk Management Supervisor completed audits on Hospital Acquired Conditions, Hospital Readmissions and Early Implementation of Medicare's Policy for Hospital-Acquired Conditions as well as a ZPIC Records Request audit performed jointly with the HIM Compliance Analyst.

- Activities performed by non-Legal & Regulatory Services staff:
  - The HIM Compliance Analyst performed monthly reviews of RAC and other government audit requests, third-party payer reviews and MS-DRG reviews. In December 2011, HIM Coding implemented a new quarterly coding compliance plan that includes random sample audits for outpatient coding staff and focused pre-bill and random sample post-bill audits for inpatient coding staff.
  - The HIM Compliance Analyst assessed coder accuracy on a quarterly basis.
  - The Chargemaster Analyst reviewed the charge description master for pricing increases.
  - Clinical Documentation staff reviewed physician documentation for all Medicare and other DRG-payer charts.
  - Nurse Case Managers continuously performed chart reviews for:
    - Ordered status agreement with Meditech status
    - Presence of an admission status letter to Medicare observation patients
    - Continued stay certification
    - Inpatient admission criteria
    - Continued stay criteria/progression of care
    - Correct admission status for chest pain patients
    - Correct admission status for one-day stays

- Scheduled for FY2013:
  - Completion of the Vendor Gift and FY2012 Big Audits (Compliance Analyst);
  - The FY2013 Big Audit to update the compilation of NRHS's auditing, monitoring, reviewing and tracking efforts (Compliance Analyst);

- Coordinate auditing efforts based on the upcoming 2014 OIG Work Plan (Compliance);
- Completion of an EMTALA audit (Risk Management);
- Coordinate with departmental compliance staff from HIM and PFS as needed on coding and billing issues, respectively; and
- Ad hoc and/or audits requested by various departments (Compliance Analyst).

I. Element Seven: Response to Detected Offenses and Continuation of Corrective Action Initiatives

Careful scrutiny of all FY2012 concerns and complaints, not including audit programs under CART's purview, revealed that none required repayment.

J. Additional Compliance activities

Identity theft:
An episode of identity theft occurred during FY2012. In September 2011 the incident came to the Patient Liaison's attention after a Texas woman contacted her. The woman had received a bill for services that she did not receive. NRHS's *Identity Theft: Red Flags Rule* policy was followed, and management's responses were appropriate and it was determined that the victim's sister was the offender. The victim filed a complaint against her sister with the Norman Police Department.

Breach notification:
A total of seven CY2011 breach notifications were submitted timely to the Secretary of Health & Human Services via the Office for Civil Rights website on February 27, 28 and 29; the submission deadline was February 29. A breach is the unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of such information. A breach is reportable unless it falls into an exception or when, once evaluated, the potential risk to the patient is significant.

K. Plans for FY2013

Scheduled:
- NRHS Compliance Week is scheduled for September 2012.
- Draft policies to detail the Compliance Committee and HIPAA Committee's responsibilities.
- Implement the mandates of the anticipated HIPAA HITECH final rule when received.
- NRHS HIPAA Privacy & Security Week will be observed in April 2013.
- Update Compliance and HIPAA training materials accordingly.
- Proceed to investigate the findings of HIT's HIPAA Privacy & Security Analyst's medical record audit findings.
- Continue participation on System Access Team, a new committee that decides whether or not to grant outside requests to NRHS computer systems.
- Support and assist the HIPAA Security Officer.
- Annual review/revision of HIPAA policy 91000-906, *Identity Theft: Red Flag Rules*.
- Provide Board education as scheduled and as needed.

Monthly monitoring (Compliance Analyst):
- Exclusions screenings
- Vendor gift reporting
- Over-limit vendors

CART auditing:

- RAC requests
- ZPIC requests
- CERT requests
- Perm requests
- Medicare pre-pay reviews
- Oklahoma Foundation for Medical Quality reviews
- Oklahoma Health Care Authority Medicaid retro reviews
- Medicare HMO reviews
- Third-party payer reviews

Areas requiring improvement:

Challenges facing Compliance staff in FY2013 include, but are not limited to:

- Strategizing to better focus the NRHS Compliance Program consistently with the OIG guidance recommendations.
- Developing improved auditing and monitoring efforts while maintaining extremely busy day-to-day compliance work.
- Analyzing the best approach for delivering a constant compliance presence at the three hospitals and the growing number of off-site locations with extremely limited resources (1.7 FTEs).
- Continue focus on RAC assessing areas of risk and taking proactive steps to minimize compliance exposure on an ongoing basis and establishing processes to help prevent future compliance issues and avoid reduced reimbursement from RAC initiatives.

Thank you for your continued support of NRHS's Compliance Program.

Sharon Parker, RN, JD
Compliance/Privacy Officer
Director, Legal & Regulatory Services

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Compliance Analyst

The Seven Elements of an Effective Compliance Program

To emphasize the importance of compliance programs, as well as to assist hospitals in their compliance efforts, the OIG has twice published guidance for hospitals. Compliance is an active, on-going process that is everyone's responsibility, and according to the *Compliance Program Guidance for Hospitals*, compliance programs should, at a minimum, include the following seven elements:

1. Standards of conduct, as well as written policies and procedures, that promote a commitment to compliance: The first element demonstrates an organization's ethical attitude and provides a process for doing the right thing.

2. Regular, effective education and training programs: Education and training are the first, and possibly the most important, defense for a compliance program.

3. Designation of a chief compliance officer, who reports directly to the CEO and the governing body, and a corporate compliance committee: The compliance officer serves "as the focal point for compliance activities" and should have "adequate resources, appropriate authority and direct access to the governing authority or an appropriate subgroup [there]of." The compliance committee serves to advise and assist the compliance officer.

4. Effective lines of communication (i.e., access to the compliance officer and a hotline to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation): The OIG stresses the importance of communication in the compliance process, and the concept of non-retaliation is fundamental.

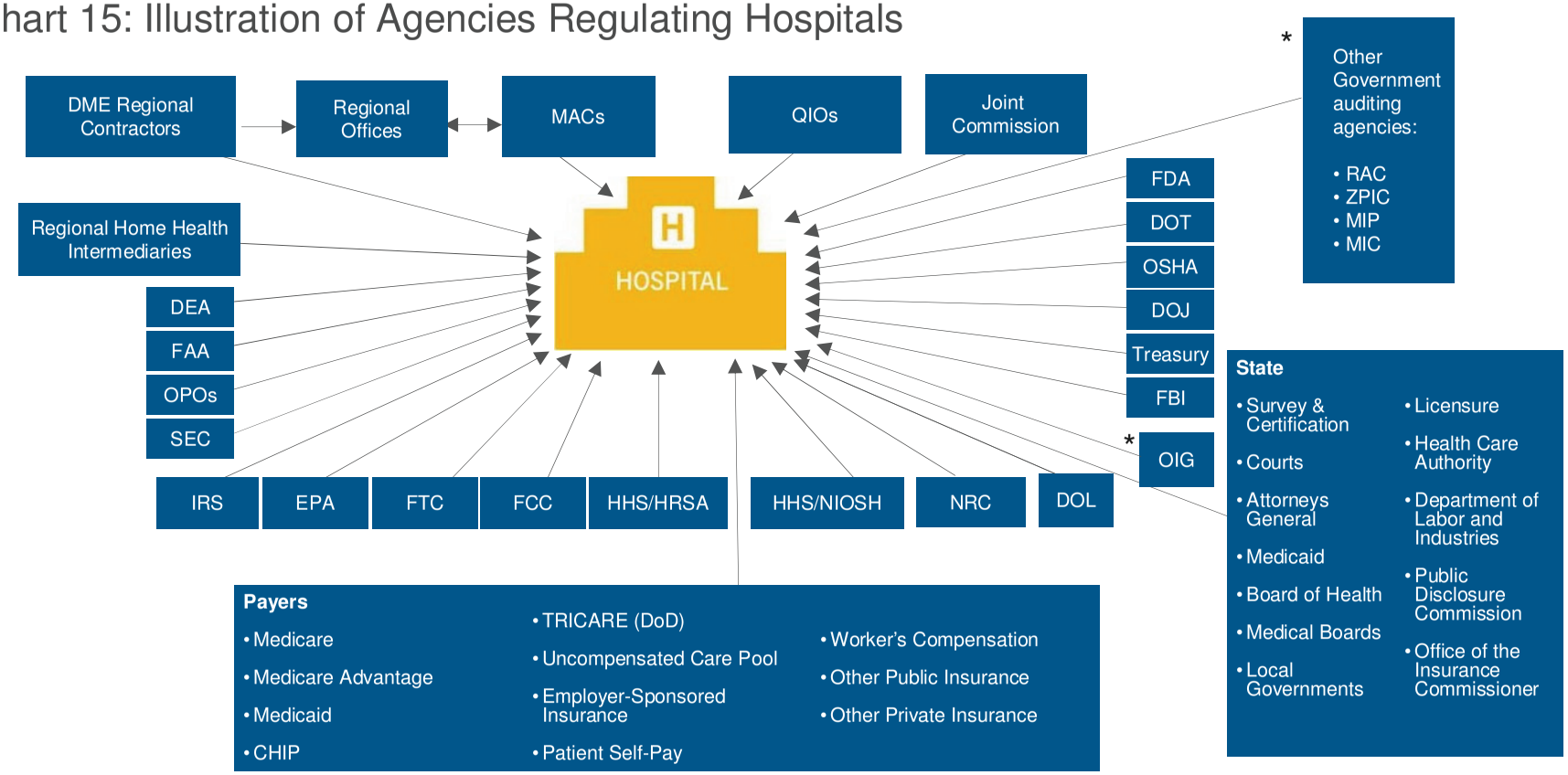
5. Enforcement of standards through well-publicized disciplinary guidelines: The OIG notes that compliance program violations and other misconduct threaten an organization's status as an honest, trustworthy, and reliable provider capable of participating in the federal health care programs.

6. Auditing and monitoring: Striving for, and demonstrating, a process for continual improvement on compliance activities, as well as ongoing evaluation, is critical.

7. Response to detected offenses and continuation of corrective action initiatives: Standards of conduct must be enforced fairly, equitably and consistently, and acts of noncompliance, whether actual misconduct or sins of omission, i.e., failure to detect or report offenses, are to be subject to discipline.

Hospitals are one of the most highly regulated sectors and face sizeable administrative costs.

Chart 15: Illustration of Agencies Regulating Hospitals



Source: Adapted from Washington State Hospital Association. (2001). *How Regulations Are Overwhelming Washington Hospitals*. Access at http://www.wsha.org/files/62/RegReform.pdf, and American Hospital Association and PricewaterhouseCoopers. (2001). *Patients or Paperwork? The Regulatory Burden Facing America's Hospitals.* Access at http://www.aha.org/aha/content/2001/pdf/FinalPaperworkReport.pdf.

American Hospital Association

* Updated by NRHS Compliance Department

Research and analysis by Avalere Health

Avalere

Statutes and Regulations that Apply to Healthcare Organizations Participating in Federal Health Programs:

The Deficit Reduction Act of 2005, under which employers who receive more than $5 million per year in Medicaid payments are required to provide information to its employees regarding the federal False Claims Act.

The False Claims Act imposes civil liability upon organizations and individuals that make, or cause to be made, false or fraudulent claims to the government. A violation can result in penalties of up to $11,000 per false claim, plus treble damages, or three times the amount that the government sustains. The government can exclude violators from all federally-funded programs, including Medicare and Medicaid.

Anti-Kickback Statutes prohibit the intentional offer, payment, solicitation, or receipt of any form of remuneration in return for the referral of Medicare or Medicaid patients. This felony offense has fines of up to $25,000 per violation, plus imprisonment of up to five years and exclusion from federally-funded programs. This statute has regulatory safe harbors.

Stark, or the Physician Self-Referral Law, bans physicians from making certain Medicare referrals to entities with which they, or their family members, have relationships. This very complex law has the same sanctions as above.

The Health Insurance Portability and Accountability Act (HIPAA) is federal legislation covering insurance portability, fraud enforcement, and administration simplification, including the Privacy and Security Rules. Both rules penalize individuals and organizations that fail to maintain the confidentiality of a patient's protected health information (PHI).

The Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of the American Recovery and Reinvestment Act of 2009, impacts NRHS's HIPAA Privacy and Security policies and procedures.

- The HITECH Act was developed through a joint effort of the Office for Civil Rights, the Office of the National Coordinator for Health Information Technology, and CMS.
- It requires technologies and methodologies that render PHI unusable, unreadable, or indecipherable to unauthorized individuals.
- HITECH addresses breach notification regulations, which, as of September 24, 2009, require covered entities to provide certain notifications following a breach of unsecured PHI.
- For purposes of the HITECH Act, electronic protected health information is considered "unsecured" unless the covered entity has satisfied certain minimum standards for the protection of that data established pursuant to the act.

The Emergency Medical Treatment and Labor Act (EMTALA), or "anti-dumping statute," is federal legislation addressing how hospitals deliver emergency medical services to the public. A hospital emergency department is prohibited from delaying care, refusing treatment, or transferring patients to another hospital based on the patient's ability to pay for services.

The Red Flags Rules are the FTC's identity theft provision, which requires financial institutions and creditors holding consumer, or other covered, accounts to develop and implement identity theft prevention programs using 26 FTC-identified red flags, i.e., patterns, practices and specific activity, that signal possible identity theft. Hospitals fall under this requirement, as the definitions of "creditor" and "covered accounts" are sufficiently broad enough to encompass patient accounts or payment plans that involve multiple transactions or multiple payments. Though the deadline to comply with the Red Flags Rules was delayed four times, ultimately until December 31, 2010, NRHS met the original November 1, 2008 deadline.

The Recovery Audit Contractor (RAC) Program's mission, as legislated in the Tax Relief and Healthcare Act of 2006, is to detect and correct past improper payments in the Medicare fee-for-service program so that actions that will prevent future improper payments can be implemented. An improper payment is any payment made by a Medicare claims processing contractor that should not have been made or was made in the wrong amount, including claims that are incorrectly submitted, contain unnecessary services or supplies, or are not supported by medical record documentation.

Top Ten Healthcare Compliance Risks

The following list of Top Ten Health Care Compliance Risks was compiled by Liles & Parker, PLLC:

1. Increased Health Care Fraud Prevention & Enforcement Action Team Activity and Enforcement: Perhaps the greatest risk is the increase in targeted health care fraud enforcement efforts by the government's Health Care Fraud Prevention and Enforcement Action Team (HEAT). These teams are comprised of top level law enforcement and professional staff from the U.S. Department of Justice (DOJ), the Department of Health and Human Services (HHS), and their various operating divisions. HEAT team initiatives have been extraordinarily successful in coordinating multi-agency efforts to both prevent health care fraud and enforce current anti-fraud initiatives. As DOJ noted in February 2012, over the previous fiscal year, DOJ and its U.S. Attorneys' Offices), OIG and CMS jointly accomplished the following:
    - Filed charges against more than 1,400 defendants in 500 cases;
    - Obtained more than 700 convictions; and
    - Recovered more than $2.4 billion under the False Claims Act.

2. Zone Program Integrity Contractor (ZPIC), Program SafeGuard Contractor (PSC) and Recovery Audit Contractor (RAC) Audits of Medicare Claims: As you already know, private contractor reviews of Medicare claims are big business – one ZPIC was awarded a five-year contract worth over $100 million. Providers can expect to see:
    - The number of ZPIC/PSC/RAC audits will greatly increase;
    - The reliance of both contractors and the government on data mining will continue to grow, and providers targeted will likely be based on utilization rates, prescribing practices and billing/coding profiles;
    - An increase in the number of Administrative Law Judge hearings in where ZPIC representatives choose to attend the hearing as participants. In these hearings, the ZPIC representative will likely aggressively oppose any arguments in support of payment that you present.

3. Electronic Medical Records: Some early adopters of Electronic Medical Record (EMR) software are now having to respond to "cloning" and/or "carry over" concerns raised by ZPICs and PSCs. In a number of cases, these audits appear to be the result, at least in part, of inadequately designed software programs which generate progress notes and other types of medical records that do not adequately require the provider to document individualized observations. Instead, the information gathered is often sparse and similar for each of the patients treated.

4. Physician Quality Reporting Initiative Issues: Under the Health Care Reform legislation passed in March 2010, the Physician Quality Reporting Initiative (PQRI) was changed from a voluntary "bonus" program to one in which penalties will be assessed if a provider does not properly participate. As of 2015, the penalty will be 1.5% and will increase to 2.0% in 2016 and subsequent years. Additionally, questions about the use of PQRI data in "Program Integrity" targeting remain unanswered.

5. Medicaid Integrity Contractors and Medicaid Recovery Audit Contractors: We have recently seen a marked increase in the number of Medicaid Integrity Contractors inquiries and audits initiated in southern states. Notably, the information and documentation requested has often been substantial. Medicaid providers must now also contend with Medicaid RACs. As a result of health care reform, Medicaid RACs are mandatory in every state.

6. HIPAA / HITECH Privacy Violations: Failure to comply with HIPAA can result in civil and / or criminal penalties. Many of these thefts could have been avoided with appropriate security. The government is serious about privacy, and you will likely see increased HIPAA/HITECH enforcement.

7. Increased Number of *Qui Tam*s Based on Overpayments: Section 6402 of the recent Health Care Reform legislation requires that all Medicare providers: (a) return and report any Medicare overpayment; and (b) explain, in writing, the reason for the overpayment. Providers have 60 days to comply with the reporting and refund requirement from the date on which the overpayment was identified or, if applicable, the date any corresponding cost report is due, whichever is later. [However], the legislation does not explain what it means to "identify" an overpayment. From a risk standpoint, this change is enormous. Disgruntled employees try to file a *qui tam* (whistleblower) lawsuit based on a provider's failure to return one or more Medicare overpayments to the program in a timely fashion. While the government may ultimately choose not to intervene in a False Claims Act case based on such allegations, a provider could spend a significant amount defending the case. Providers should ensure that billing personnel understand the importance of returning any overpayments identified as quickly as possible.

8. Third-Party Payor Actions: Third-party payors are participating in Health Care Fraud Working Group meetings with DOJ and other federal agents. The last year [has] seen an increase in the number of "copycat" audits initiated by third-party payor "Special Investigative Units" (SIUs). Once the government has announced the results of a significant audit, the third-party payor considers the services at issue and reviews whether it may have also been wrongly billed for such services. If so, their SIU opens a new investigation against the provider.

9. Employee Screening: With the expansion of the permissive exclusion authorities, more and more individuals will ultimately be excluded from Medicare, [and] the OIG is actively reviewing whether Medicare providers have employed individuals who have been excluded. In one recent case, OIG announced that it had assessed significant civil monetary penalties against a health care provider that employed seven individuals who the provider "knew or should have known" had been excluded from participation in federal health care programs. These individuals were alleged to have furnished items and services for which the provider was paid by federal health care programs. All providers should periodically screen their staff against the OIG and GSA databases to ensure that their employees have not been excluded.

10. Payment Suspension Actions: In late 2010, Medicare contractors recommended to CMS that this extraordinary step be taken against providers in connection with a wide variety of alleged infractions. Reasons given for suspending a provider's Medicare number included, but were not limited to: (1) the provider failed to properly notify Medicare of a change in location, (2) the provider allegedly engaged in improper billing practices, and (3) the provider failed to fully cooperate during a site visit.

CORPORATE RESPONSIBILITY AND CORPORATE COMPLIANCE:

A Resource for Health Care Boards of Directors

THE OFFICE OF INSPECTOR GENERAL OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

THE AMERICAN HEALTH LAWYERS ASSOCIATION

ACKNOWLEDGEMENT

This educational resource represents a unique collaboration between the American Health Lawyers Association and the Office of the Inspector General of the United States Department of Health and Human Services. This publication would have not been possible without the dedicated effort of numerous individuals at both organizations. It is intended to be a useful resource for those serving on the Boards of Directors of our nation's health care institutions.

I. INTRODUCTION

As corporate responsibility issues fill the headlines, corporate directors are coming under greater scrutiny. The Sarbanes-Oxley Act, state legislation, agency pronouncements, court cases and scholarly writings offer a myriad of rules, regulations, prohibitions, and interpretations in this area. While all Boards of Directors must address these issues, directors of health care organizations also have important responsibilities that need to be met relating to corporate compliance requirements unique to the health care industry. The expansion of health care regulatory enforcement and compliance activities and the heightened attention being given to the responsibilities of corporate directors are critically important to all health care organizations. In this context, enhanced oversight of corporate compliance programs is widely viewed as consistent with and essential to ongoing federal and state corporate responsibility initiatives.

Our complex health care system needs dedicated and knowledgeable directors at the helm of both for-profit and non-profit corporations. This educational resource, co-sponsored by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services and the American Health Lawyers Association, the leading health law educational organization, seeks to assist directors of health care organizations in carrying out their important oversight responsibilities in the current challenging health care environment. Improving the knowledge base and effectiveness of those serving on health care organization boards will help to achieve the important goal of continuously improving the U.S. health care system.

Fiduciary Responsibilites

The fiduciary duties of directors reflect the expectation of corporate stakeholders regarding oversight of corporate affairs. The basic fiduciary duty of care principle, which requires a director to act in good faith with the care an ordinarily prudent person would exercise under similar circumstances, is being tested in the current corporate climate. Personal liability for directors, including removal, civil damages, and tax liability, as well as damage to reputation, appears not so far from reality as once widely believed. Accordingly, a basic understanding of the director's fiduciary obligations and how the duty of care may be exercised in overseeing the company's compliance systems has become essential.

Embedded within the duty of care is the concept of reasonable inquiry. In other words, directors should make inquiries to management to obtain information necessary to satisfy their duty of care. Although in the *Caremark* case, also discussed later in this educational resource, the court found that the Caremark board did not breach its fiduciary duty, the court's opinion also stated the following: "[A] director's obligation includes a duty to attempt in good faith to assure that a corporate information and reporting system, which the Board concludes is adequate, exists, and that failure to do so under some circumstances, may, in theory at least, render a director liable for losses caused by non-compliance with applicable legal standards." Clearly, the organization may be at risk and directors, under extreme circumstances, also may be at risk if they fail to reasonably oversee the organization's compliance program or act as mere passive recipients of information.

On the other hand, courts traditionally have been loath to second-guess Boards of Directors that have followed a careful and thoughtful process in their deliberations, even where ultimate outcomes for the corporation have been negative. Similarly, courts have consistently upheld the distinction between the duties of Boards of Directors and the duties of management. The responsibility of directors is to provide oversight, not manage day-to-day affairs. It is the process the Board follows in establishing that it had access to sufficient information and that it has asked appropriate questions that is most critical to meeting its duty of care.

Purpose of this Document

This educational resource is designed to help health care organization directors ask knowledgeable and appropriate questions related to health care corporate compliance. These questions are not intended to set forth any specific standard of care. Rather, this resource will help corporate directors to establish, and affirmatively demonstrate, that they have followed a reasonable compliance oversight process.

Of course, the circumstances of each organization differ and application of the duty of care and consequent reasonable inquiry will need to be tailored to each specific set of facts and circumstances. However, compliance with the fraud and abuse laws and other federal and state regulatory laws applicable to health care organizations is essential for the lawful behavior and corporate success of such organizations. While these laws can be complex, effective compliance is an asset for both the organization and the health care delivery system. It is hoped that this educational resource is useful to health care organization directors in exercising their oversight responsibilities and supports their ongoing efforts to promote effective corporate compliance.

II. DUTY OF CARE

Of the principal fiduciary obligations/duties owed by directors to their corporations, the one duty specifically implicated by corporate compliance programs is the *duty of care.*[1]

As the name implies, the *duty of care* refers to the obligation of corporate directors to exercise the proper amount of care in their decision-making process. State statutes that create the duty of care and court cases that interpret it usually are identical for both for-profit and non-profit corporations.

In most states, duty of care involves determining whether the directors acted (1) in "good faith," (2) with that level of care that an ordinarily prudent person would exercise in like circumstances, and (3) in a manner that they reasonably believe is in the best interest of the corporation. In analyzing whether directors have complied with this duty, it is necessary to address each of these elements separately.

The "good faith" analysis usually focuses upon whether the matter or transaction at hand involves any improper financial benefit to an individual, and/or whether any intent exists to take advantage of the corporation (a corollary to the duty of loyalty). The "reasonable inquiry" test asks whether the directors conducted the appropriate level of due diligence to allow them to make an informed decision. In other words, directors must be aware of what is going on about them in the corporate business and must in appropriate circumstances make such reasonable inquiry, as would an ordinarily prudent person under similar circumstances. And, finally, directors are obligated to act in a manner that they reasonably believe to be in the best interests of the corporation. This normally relates to the directors' state of mind with respect to the issues at hand.

In considering directors' fiduciary obligations, it is important to recognize that the appropriate standard of care is not "perfection." Directors are *not* required to know everything about a topic they are asked to consider. They may, where justified, rely on the advice of management and of outside advisors.

Furthermore, many courts apply the "business judgment rule" to determine whether a director's duty of care has been met with respect to corporate decisions. The rule provides, in essence, that a director will not be held liable for a decision made in good faith, where the director is disinterested, reasonably informed under the circumstances, and rationally believes the decision to be in the best interest of the corporation.

Director obligations with respect to the duty of care arise in two distinct contexts:

- The *decision-making function*: The application of duty of care principles to a specific decision or a particular board action; and
- The *oversight function*: The application of duty of care principles with respect to the general activity of the board in overseeing the day-to-day business operations of the corporation; *i.e.*, the exercise of reasonable care to assure that corporate executives carry out their management responsibilities and comply with the law.

Directors' obligations with respect to corporate compliance programs arise within the context of that oversight function. The leading case in this area, viewed as applicable to all health care organizations, provides that a director has two principal obligations with respect to the oversight function. A director has a duty to attempt in good faith to assure that (1) a corporate information and reporting system exists, and (2) this reporting system is adequate to assure the board that appropriate information as to compliance with applicable laws will come to its attention in a timely manner as a matter of ordinary operations.[2] In *Caremark,* the court addressed the circumstances in which corporate directors may be held liable for breach of the duty of care by failing to adequately supervise corporate employees whose misconduct caused the corporation to violate the law.

In its opinion, the *Caremark* court observed that the level of detail that is appropriate for such an information system is a matter of business judgment. The court also acknowledged that no rationally designed information and reporting system will remove the possibility that the corporation will violate applicable laws or otherwise fail to identify corporate acts potentially inconsistent with relevant law.

Under these circumstances, a director's failure to reasonably oversee the implementation of a compliance program may put the organization at risk and, under extraordinary circumstances, expose individual directors to personal liability for losses caused by the corporate non-

1 The other two core fiduciary duty principals are the duty of loyalty and the duty of obedience to purpose.

2 *In re Caremark International Inc. Derivative Litigation,* 698 A.2d 959 (Del. Ch. 1996). A shareholder sued the Board of Directors of Caremark for breach of the fiduciary duty of care. The lawsuit followed a multi-million dollar civil settlement and criminal plea relating to the payment of kickbacks to physicians and improper billing to federal health care programs.

compliance.[3] Of course, crucial to the oversight function is the fundamental principle that a director is entitled to rely, in good faith, on officers and employees as well as corporate professional experts/advisors in whom the director believes such confidence is merited. A director, however, may be viewed as not acting in good faith if he/she is aware of facts suggesting that such reliance is unwarranted.

In addition, the duty of care test involving reasonable inquiry has not been interpreted to require the director to exercise "proactive vigilance" or to "ferret out" corporate wrongdoing absent a particular warning or a "red flag." Rather, the duty to make reasonable inquiry increases when "suspicions are aroused or *should be aroused;"* that is, when the director is presented with extraordinary facts or circumstances of a material nature (*e.g.,* indications of financial improprieties, self-dealing, or fraud) or a major governmental investigation. Absent the presence of suspicious conduct or events, directors are entitled to rely on the senior leadership team in the performance of its duties. Directors are not otherwise obligated to anticipate future problems of the corporation.

Thus, in exercising his/her duty of care, the director is obligated to exercise general supervision and control with respect to corporate officers. However, once presented (through the compliance program or otherwise) with information that causes (or should cause) concerns to be aroused, the director is then obligated to make further inquiry until such time as his/her concerns are satisfactorily addressed and favorably resolved. Thus, while the corporate director is not expected to serve as a compliance officer, he/she is expected to oversee senior management's operation of the compliance program.

III. The Unique Challenges of Health Care Organization Directors

The health care industry operates in a heavily regulated environment with a variety of identifiable risk areas. An effective compliance program helps mitigate those risks. In addition to the challenges associated with patient care, health care providers are subject to voluminous and sometimes complex sets of rules governing the coverage and reimbursement of medical services. Because federal and state-sponsored health care programs play such a significant role in paying for health care, material non-compliance with these rules can present substantial risks to the health care provider. In addition to recoupment of improper payments, the Medicare, Medicaid and other government health care programs can impose a range of sanctions against health care businesses that engage in fraudulent practices.

Particularly given the current "corporate responsibility" environment, health care organization directors should be concerned with the manner in which they carry out their duty to oversee corporate compliance programs. Depending upon the nature of the corporation, there are a variety of parties that might in extreme circumstances seek to hold corporate directors personally liable for allegedly breaching the duty of oversight with respect to corporate compliance. With respect to for-profit corporations, the most likely individuals to bring a case against the directors are corporate shareholders in a derivative suit, or to a limited degree, a regulatory agency such as the Securities and Exchange Commission. With respect to non-profit corporations, the most likely person to initiate such action is the state attorney general, who may seek equitable relief against the director (*e.g.,* removal) or damages. It is also possible (depending upon state law) that a dissenting director, or the corporate member, could assert a derivative-type action against the directors allegedly responsible for the "inattention," seeking removal or damages.

Over the last decade, the risks associated with non-compliance have grown dramatically. The government has dedicated substantial resources, including the addition of criminal investigators and prosecutors, to respond to health care fraud and abuse. In addition to government investigators and auditors, private whistleblowers play an important role in identifying allegedly fraudulent billing schemes and other abusive practices. Health care providers can be found liable for submitting claims for reimbursement in reckless disregard or deliberate ignorance of the truth, as well as for intentional fraud. Because the False Claims Act authorizes the imposition of damages of up to three times the amount of the fraud and civil monetary penalties of $11,000 per false claim, record level fines and penalties have been imposed against individuals and health care organizations that have violated the law.

In addition to criminal and civil monetary penalties, health care providers that are found to have defrauded the federal health care programs may be excluded from participation in these programs. The effect of an exclusion can be profound because those excluded will not

3 Law is not static, and different states will have different legal developments and standards. Standards may also vary depending on whether an entity is for profit or non-profit. Boards of public health care entities may have additional statutory obligations and should be aware of state and federal statutory requirements applicable to them.

receive payment under Medicare, Medicaid or other federal health care programs for items or services provided to program beneficiaries. The authorities of the OIG provide for mandatory exclusion for a minimum of five years for a conviction with respect to the delivery of a health care item or service. The presence of aggravating circumstances in a case can lead to a lengthier period of exclusion. Of perhaps equal concern to board members, the OIG also has the discretion to exclude providers for certain conduct even absent a criminal conviction. Such conduct includes participation in a fraud scheme, the payment or receipt of kickbacks, and failing to provide services of a quality that meets professionally recognized standards. In lieu of imposing exclusion in these instances, the OIG may require an organization to implement a comprehensive compliance program, requiring independent audits, OIG oversight and annual reporting requirements, commonly referred to as a Corporate Integrity Agreement.

IV. The Development of Compliance Programs

In light of the substantial adverse consequences that may befall an organization that has been found to have committed health care fraud, the health care industry has embraced efforts to improve compliance with federal and state health care program requirements. As a result, many health care providers have developed active compliance programs tailored to their particular circumstances. A recent survey by the Health Care Compliance Association, for example, has found that in just three years, health care organizations with active compliance programs have grown from 55 percent in 1999 to 87 percent in 2002. In support of these efforts, the OIG has developed a series of provider-specific compliance guidances. These voluntary guidelines identify risk areas and offer concrete suggestions to improve and enhance an organization's internal controls so that its billing practices and other business arrangements are in compliance with Medicare's rules and regulations.

As compliance programs have matured and new challenges have been identified, health care organization boards of directors have sought ways to help their organization's compliance program accomplish its objectives. Although health care organization directors may come from diverse backgrounds and business experiences, an individual director can make a valuable contribution toward the compliance objective by asking practical questions of management and contributing his/her experiences from other industries. While the opinion in *Caremark* established a Board's duty to oversee a compliance program, it did not enumerate a specific methodology for doing so. It is therefore important that directors participate in the development of this process. This educational resource is designed to assist health care organization directors in exercising that responsibility.

V. Suggested Questions for Directors

Periodic consideration of the following questions and commentary may be helpful to a health care organization's Board of Directors. The structural questions explore the Board's understanding of the scope of the organization's compliance program. The remaining questions, addressing operational issues, are directed to the operations of the compliance program and may facilitate the Board's understanding of the vitality of its compliance program.

STRUCTURAL QUESTIONS

1. **How is the compliance program structured and who are the key employees responsible for its implementation and operation? How is the Board structured to oversee compliance issues?**

The success of a compliance program relies upon assigning high-level personnel to oversee its implementation and operations. The Board may wish as well to establish a committee or other subset of the Board to monitor compliance program operations and regularly report to the Board.

2. **How does the organization's compliance reporting system work? How frequently does the Board receive reports about compliance issues?**

Although the frequency of reports on the status of the compliance program will depend on many circumstances, health care organization Boards should receive reports on a regular basis. Issues that are frequently addressed include (1) what the organization has done in the past with respect to the program and (2) what steps are planned for the future and why those steps are being taken.

3. **What are the goals of the organization's compliance program? What are the inherent limitations in the compliance program? How does the organization address these limitations?**

The adoption of a corporate compliance program by an organization creates standards and processes that it should be able to rely upon and against which it may be held accountable. A solid understanding of the rationale and objectives of the compliance program, as well as its goals and inherent limitations, is essential if the Board is to evaluate the reasonableness of its design and the effectiveness of its operation. If the Board has unrealistic expectations of its compliance program, it may place undue reliance

on its ability to detect vulnerabilities. Furthermore, compliance programs will not prevent all wrongful conduct and the Board should be satisfied that there are mechanisms to ensure timely reporting of suspected violations and to evaluate and implement remedial measures.

4. **Does the compliance program address the significant risks of the organization? How were those risks determined and how are new compliance risks identified and incorporated into the program?**

Health care organizations operate in a highly regulated industry and must address various standards, government program conditions of participation and reimbursement, and other standards applicable to corporate citizens irrespective of industry. A comprehensive ongoing process of compliance risk assessment is important to the Board's awareness of new challenges to the organization and its evaluation of management's priorities and program resource allocation.

5. **What will be the level of resources necessary to implement the compliance program as envisioned by the Board? How has management determined the adequacy of the resources dedicated to implementing and sustaining the compliance program?**

From the outset, it is important to have a realistic understanding of the resources necessary to implement and sustain the compliance program as adopted by the Board. The initial investment in establishing a compliance infrastructure and training the organization's employees can be significant. With the adoption of a compliance program, the organization is making a long term commitment of resources because effective compliance systems are not static programs but instead embrace continuous improvement. Quantifying the organization's investment in compliance efforts gives the Board the ability to consider the feasibility of implementation plans against compliance program goals. Such investment may include annual budgetary commitments as well as direct and indirect human resources dedicated to compliance. To help ensure that the organization is realizing a return on its compliance investment, the Board also should consider how management intends to measure the effectiveness of its compliance program. One measure of effectiveness may be the Board's heightened sensitivity to compliance risk areas.

OPERATIONAL QUESTIONS

The following questions are suggested to assist the Board in its periodic evaluation of the effectiveness of the organization's compliance program and the sufficiency of its reporting systems.

A. Code of Conduct

How has the Code of Conduct or its equivalent been incorporated into corporate policies across the organization? How do we know that the Code is understood and accepted across the organization? Has management taken affirmative steps to publicize the importance of the Code to all of its employees?

Regardless of its title, a Code of Conduct is fundamental to a successful compliance program because it articulates the organization's commitment to ethical behavior. The Code should function in the same way as a constitution, *i.e.*, as a document that details the fundamental principles, values, and framework for action within the organization. The Code of Conduct helps define the organization's culture; all relevant operating policies are derivative of its principles. As such, codes are of real benefit only if meaningfully communicated and accepted throughout the organization.

B. Policies and Procedures

Has the organization implemented policies and procedures that address compliance risk areas and established internal controls to counter those vulnerabilities?

If the Code of Conduct reflects the organization's ethical philosophy, then its policies and procedures represent the organization's response to the day-to-day risks that it confronts while operating in the current health care system. These policies and procedures help reduce the prospect of erroneous claims, as well as fraudulent activity by identifying and responding to risk areas. Because compliance risk areas evolve with the changing reimbursement rules and enforcement climate, the organization's policies and procedures also need periodic review and, where appropriate, revision.[4] Regular consultation with counsel, including reports to the Board, can assist the Board in its oversight responsibilities in this changing environment.

4 There are a variety of materials available to assist health care organizations in this regard. For example, both sponsoring organizations of this educational resource offer various materials and guidance, accessible through their web sites.

C. Compliance Infrastructure

1. **Does the Compliance Officer have sufficient authority to implement the compliance program? Has management provided the Compliance Officer with the autonomy and sufficient resources necessary to perform assessments and respond appropriately to misconduct?**

Designating and delegating appropriate authority to a compliance officer is essential to the success of the organization's compliance program. For example, the Compliance Officer must have the authority to review all documents and other information that are relevant to compliance activities. Boards should ensure that lines of reporting within management and to the Board, and from the Compliance Officer and consultants, are sufficient to ensure timely and candid reports for those responsible for the compliance program. In addition, the Compliance Officer must have sufficient personnel and financial resources to implement fully all aspects of the compliance program.

2. **Have compliance-related responsibilities been assigned across the appropriate levels of the organization? Are employees held accountable for meeting these compliance-related objectives during performance reviews?**

The successful implementation of a compliance program requires the distribution throughout the organization of compliance-related responsibilities. The Board should satisfy itself that management has developed a system that establishes accountability for proper implementation of the compliance program. The experience of many organizations is that program implementation lags where there is poor distribution of responsibility, authority and accountability beyond the Compliance Officer.

D. Measures to Prevent Violations

1. **What is the scope of compliance-related education and training across the organization? Has the effectiveness of such training been assessed? What policies/measures have been developed to enforce training requirements and to provide remedial training as warranted?**

A critical element of an effective compliance program is a system of effective organization-wide training on compliance standards and procedures. In addition, there should be specific training on identified risk areas, such as claims development and submission, and marketing practices. Because it can represent a significant commitment of resources, the Board should understand the scope and effectiveness of the educational program to assess the return on that investment.

2. **How is the Board kept apprised of significant regulatory and industry developments affecting the organization's risk? How is the compliance program structured to address such risks?**

The Board's oversight of its compliance program occurs in the context of significant regulatory and industry developments that impact the organization not only as a health care organization but more broadly as a corporate entity. Without such information, it cannot reasonably assess the steps being taken by management to mitigate such risks and reasonably rely on management's judgment.

3. **How are "at risk" operations assessed from a compliance perspective? Is conformance with the organization's compliance program periodically evaluated? Does the organization periodically evaluate the effectiveness of the compliance program?**

Compliance risk is further mitigated through internal review processes. Monitoring and auditing provide early identification of program or operational weaknesses and may substantially reduce exposure to government or whistleblower claims. Although many assessment techniques are available, one effective tool is the performance of regular, periodic compliance audits by internal or external auditors. In addition to evaluating the organization's conformance with reimbursement or other regulatory rules, or the legality of its business arrangements, an effective compliance program periodically reviews whether the compliance program's elements have been satisfied.

4. **What processes are in place to ensure that appropriate remedial measures are taken in response to identified weaknesses?**

Responding appropriately to deficiencies or suspected non-compliance is essential. Failure to comply with the organization's compliance program, or violation of applicable laws and other types of misconduct, can threaten the organization's status as a reliable and trustworthy provider of health care. Moreover, failure to respond to a known deficiency may be considered an aggravating circumstance in evaluating the organization's potential liability for the underlying problem.

E. Measures to Respond to Violations

1. What is the process by which the organization evaluates and responds to suspected compliance violations? How are reporting systems, such as the compliance hotline, monitored to verify appropriate resolution of reported matters?

Compliance issues may range from simple overpayments to be returned to the payor to possible criminal violations. The Board's duty of care requires that it explore whether procedures are in place to respond to credible allegations of misconduct and whether management promptly initiates corrective measures. Many organizations take disciplinary actions when a responsible employee's conduct violates the organization's Code of Conduct and policies. Disciplinary measures should be enforced consistently.

2. Does the organization have policies that address the appropriate protection of "whistleblowers" and those accused of misconduct?

For a compliance program to work, employees must be able to ask questions and report problems. In its fulfillment of its duty of care, the Board should determine that the organization has a process in place to encourage such constructive communication.

3. What is the process by which the organization evaluates and responds to suspected compliance violations? What policies address the protection of employees and the preservation of relevant documents and information?

Legal risk may exist based not only on the conduct under scrutiny, but also on the actions taken by the organization in response to the investigation. In addition to a potential obstruction of a government investigation, the organization may face charges by employees that it has unlawfully retaliated or otherwise violated employee rights. It is important, therefore, that organizations respond appropriately to a suspected compliance violation and, more critically, to a government investigation without damaging the corporation or the individuals involved. The Board should confirm that processes and policies for such responses have been developed in consultation with legal counsel and are well communicated and understood across the organization.

4. What guidelines have been established for reporting compliance violations to the Board?

As discussed, the Board should fully understand management's process for evaluating and responding to identified violations of the organization's policies, as well as applicable federal and state laws. In addition, the Board should receive sufficient information to evaluate the appropriateness of the organization's response.

5. What policies govern the reporting to government authorities of probable violations of law?

Different organizations will have various policies for investigating probable violations of law. Federal law encourages organizations to self-disclose wrongdoing to the federal government. Health care organizations and their counsel have taken varied approaches to making such disclosures. Boards may want to inquire as to whether the organization has developed a policy on when to consider such disclosures.

VI. Conclusion

The corporate director, whether voluntary or compensated, is a bedrock of the health care delivery system. The oversight activities provided by the director help form the corporate vision, and at the same time promote an environment of corporate responsibility that protects the mission of the corporation and the health care consumers it serves.

Even in this "corporate responsibility" environment, the health care corporate director who is mindful of his/her fundamental duties and obligations, and sensitive to the premises of corporate responsibility, should be confident in the knowledge that he/she can pursue governance service without needless concern about personal liability for breach of fiduciary duty and without creating an adversarial relationship with management.

The perspectives shared in this educational resource are intended to assist the health care director in performing the important and necessary service of oversight of the corporate compliance program. In so doing, it is hoped that fiduciary service will appear less daunting, and provide a greater opportunity to "make a difference" in the delivery of health care.

Compliance Capsule

Name NORMAN REGIONAL STAFF

Prescription: Take one Capsule PRN to enhance compliance!

Making Excellence a Habit

This year's NRHS Compliance Week theme is "Making Excellence a Habit." But what does that mean, and what does it take?

At Norman Regional Health System, *COMPLIANCE* is doing the right thing. And *EXCELLENCE* is defined, by the *New Oxford English Dictionary*, as the quality of being outstanding or extremely good. So, how do we become outstanding in compliance? By doing the right thing every time.

Turning a behavior into a habit takes practice. By practicing compliance we become excellent in compliance because we are doing the right thing every time. And through that process we forge the new habit.

Once we cultivate that habit of excellence, we do the right thing every time as a matter of routine. *Making Excellence a Habit*… It's the Norman Regional way!

Signature R. U. Compliant, MD

Questions?
Compliance Analyst Shawn Stone can be reached at 307-1064.

Compliance Capsule

Name NORMAN REGIONAL STAFF

Prescription: Take one Capsule PRN to enhance compliance!

More Ways to Forge that New Habit

So, you are "Making Excellence a Habit" by doing the right thing every time. But what else can you do to help forge the habit?

Here are some simple things to make compliance a part of your day-to-day efforts:

- Learn and be able to articulate the ways in which your job is critical to NRHS's compliance efforts.
- Consider how errors could place NRHS in jeopardy.
- Be willing to take extra steps concerning your compliance duties: ask hard questions and double-check policies and/or ask your supervisor.
- Read NRHS's Code of Conduct and act in accordance with it; don't just give it lip service.
- Know that it is better to ask questions and raise issues than to leave issues unresolved.
- View compliance as an opportunity rather than a burden, and consider it to be a critical component of NRHS's overall quality-improvement process.
- Request training and education as needed.
- When new policies or procedures are introduced, take time to read them and incorporate them into your job. If you are confused, ask questions. Be flexible. Understand that changes are bound to happen.
- When in doubt, point it out.

Signature R. U. Compliant, MD

Questions?
Compliance Analyst Shawn Stone can be reached at 307-1064.

Compliance Capsule

Name NORMAN REGIONAL STAFF

Prescription: Take one Capsule PRN to enhance compliance!

Easy Question?

Obviously NRHS Compliance Week is a great time to focus on compliance and to heighten our compliance awareness. And as we've tackled this year's theme, "Making Excellence a Habit," and looked at how to bring that theme to life this week, we have learned some easy ways to bring compliance to the forefront.

But what else can you do? Well, have you ever asked yourself, "Am I compliant?"

Easy question, right? Or *is* it?

There are not many gray areas in compliance, which makes it a yes-or-no question. Either you are compliant, or you are not.

Think about it… if you're compliant some of the time, or if you're compliant most of the time, or if you are compliant until it is inconvenient, can you really answer "yes" to the above question? Not so much.

So, yes or no: Are you compliant?

Signature R. U. Compliant, MD

Questions?
Compliance Analyst Shawn Stone can be reached at 307-1064.

Compliance Capsule

Name NORMAN REGIONAL STAFF

Prescription: Take one Capsule PRN to enhance compliance!

HIPAA Qs and As: Compliance & Privacy Hotline
NRHS HIPAA Quick Reference Guide is HIPAA Central!

What if I have concerns or questions about a privacy or compliance issue? There are certain things at the core of NRHS's values, and among them are:

- Compliance with laws and regulations;
- Protecting patient information; and
- Ethical behavior.

That's why the Compliance & Privacy Hotline was established!

If you have concerns or questions about a privacy issue or an ethical or legal compliance issue, you can call the Hotline:

1-877-267-1929

The Hotline is:
- Toll-free; and
- Available 24/7.

Hotline calls:
- Are not recorded;
- Are confidential; and
- Can be made anonymously.

And remember: Retaliation against anyone who calls the Compliance & Privacy Hotline is strictly prohibited!

Signature R. U. Compliant, MD

Questions?
Compliance Analyst Shawn Stone can be reached at 307-1064.

Compliance Capsule

Name NORMAN REGIONAL STAFF

Prescription: Take one capsule PRN to enhance compliance!

Code Gold: Watch for your new copy of the Code of Conduct
Gold booklet holds the key to doing NRHS business

Following a scheduled revision, the NRHS Code of Conduct booklet (Code) is hot off the press and headed your way! That's right: The new Code will be distributed to each and every employee. And to re-commit to doing the right thing, everyone is required to sign the Certification Agreement of Compliance, which will be filed in employees' files in Human Resources.

The most obvious change to the Code is the format, which is now one column per page. But that's not all!

- New sections in the revised Code include:
  - Ineligible Persons;
  - Mandatory Annual Compliance and HIPAA Training;
  - Obligation to Report; and
  - Code Acknowledgement Process
- Updated sections include:
  - Workplace Behavior and Equal Employment Opportunities;
  - Patient Rights;
  - Electronic Media, Social Media and HIPAA Security Standards;
  - Patient Medical Records, Coding and Billing of Services;
  - Confidentiality, Privacy & Security of Patient and Hospital Information;
  - Business Ethics; and
  - Business Courtesies, Gifts and Customer/ Supplier Relations

Signature R. U. Compliant, M.D.

Questions?
Compliance Analyst Shawn Stone can be reached at 307-1064.

Compliance Capsule

Name NORMAN REGIONAL STAFF

Prescription: Take one Capsule PRN to enhance compliance!

Ask Dr. Compliant

Dear Dr. Compliant,
I saw someone take a picture of a patient's body part with her smart phone. She isn't an employee, but she occasionally comes here to provide a service. I know that employees cannot take pictures, but I didn't know what to do in this situation. What should I have done?

Signed,
Camera shy

Dear C.S.,
Let's bring this into focus: With a few exceptions (e.g., wound care, newborn babies and clinic patient identification), photographing patients is not permitted at Norman Regional Health System. And it certainly is not appropriate for any such photography to be done with personal equipment. NRHS requires everyone who provides services here to abide by our Code of Conduct, policies, procedures and practices just as though they were employed here, so it was improper for the person in question to take the photograph.

Picture these scenarios: Next time you inform her that taking a picture is inappropriate, and you notify your manager or director as soon as possible so that he/she can follow up with the person. And either you or your manager/director notify the Compliance/Privacy Officer. Or, if you are uncomfortable with confronting her, you immediately notify your manager/director so that he/she can address the issue and alert the Compliance/Privacy Officer.

Remember, you are required to report potential, suspected and actual violations of our HIPAA and Compliance policies, so: **When in doubt, point it out!**

Signature R. U. Compliant, MD

Questions?
Compliance Analyst Shawn Stone can be reached at 307-1064.

Name NORMAN REGIONAL STAFF

Prescription: Take one Capsule PRN to enhance compliance!

Cracking the Code: Deciphering the NRHS Code of Conduct
Page Two: Ineligible Persons and Conflicts of Interest

The federal government prohibits NRHS from employing, contracting with, or billing for services rendered by ineligible persons. "Ineligible persons" are: currently excluded, suspended, debarred or otherwise ineligible to participate in federal health care programs including Medicaid and Medicare; have been convicted of a crime related to the provision of health care; or have not been reinstated after a period of exclusion. To comply, NRHS regularly screens employees against databases that list all ineligible persons.

Every person who works for, or provides services at, NRHS is expected to avoid conflicts of interest, which occur when outside activities, personal financial interests or other personal interests influence, or appear to influence, objective decision making. If you are concerned that any of your outside activities or personal interests might appear to be a conflict of interest, discuss the matter with your Supervisor, Manager, or Director.

Ask yourself:
Do I know that I am required to report an investigation that could lead to my exclusion, debarment, or ineligibility to participate in federal healthcare programs including Medicare and Medicaid?

Do I consider whether my actions are right, fair, legal and free of conflicts of interest? Can my actions withstand outside scrutiny?

Have I finished reading my new copy of the Code of Conduct yet? If not, why not???

Signature R. U. Compliant, M.D.

Questions?
Compliance Analyst Shawn Stone can be reached at 307-1064.

Compliance Capsule

Name NORMAN REGIONAL STAFF

Prescription: Take one Capsule PRN to enhance compliance!

I SPY: The Importance of Security & Privacy to You

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, is federal legislation that impacts healthcare professionals. HIPAA ensures access to quality healthcare coverage for people between jobs, protects private healthcare information, creates a uniform standard for dispersing personal information and prevents abuse, fraud and waste.

HIPAA is comprised of the Privacy Rule and the Security Rule and has three components: protection for the privacy of Protected Health Information (PHI); protection for the security of PHI; and standardization of electronic data.

The Privacy Rule applies to all forms of individuals' PHI, whether electronic, written, or oral. Key elements of the Privacy Rule include covered entities, business associates, uses and disclosures, individual rights, administrative requirements, and compliance and enforcement.

On the other hand, the Security Rule protects health information in electronic form and requires entities covered by HIPAA to ensure that electronic PHI secure. The Security Rule's components include administrative, technical, and physical safeguards.

NRHS's Privacy Officer is Sharon Parker, director of Legal & Regulatory Services and John Meharg, director of Health Information Technology is the HIPAA Security Officer. NRHS also has a HIPAA Committee. These individuals, and others, work to ensure that NRHS is HIPAA-compliant.

Signature R. U. Compliant, M.D.

Questions?
Compliance Analyst Shawn Stone can be reached at 307-1064.

Compliance Capsule

Name NORMAN REGIONAL STAFF

Prescription: Take one Capsule PRN to enhance compliance!

I SPY… My own PHI?

It is not Norman Regional's practice to allow employees to access their own Protected Health Information ("PHI"). In fact, it is prohibited, and doing so results in disciplinary action, up to and including termination.

But why can't NRHS employees access their medical records through the EMR?

Simply put, the HIPAA Privacy Rule allows employees to access, use and disclose the minimum PHI necessary to perform the task at hand. This is the "minimum necessary" requirement, a basic tenet of HIPAA.

Employees should not work in their own medical records which means that the minimum necessary requirement does not apply. So if you access your own PHI —or anyone else's— for any reason other than to perform the intended work-related purpose of the use or disclosure, you are violating HIPAA.

In order to access their hospital records, patients, including employee/patients, must sign an authorization form, available in the HIM Department of all NRHS hospitals.

Signature R. U. Compliant, M.D.

Questions?
Compliance Analyst Shawn Stone can be reached at 307-1064.

NRHS Compliance Week
September 12 – 16, 2011

Making Excellence a Habit

Scavenger Hunt

Instructions:

1. Using the appropriate Compliance reference materials, answer the following questions of the answer sheet.
2. Send the completed answer sheet to

Shawn Stone
Compliance Dept.

3. Entries must reach Shawn by Wednesday morning, Sept. 21st. The drawing will be Wednesday afternoon.

Answer the following questions using a gold Compliance & Privacy Hotline flyer:

1. How many telephones are pictured on the poster for the Compliance & Privacy Hotline?
2. What is the Compliance & Privacy Hotline phone number?

Answer the following questions using a gold Code of Conduct booklet:

3. What quotation is on the cover of the Code of Conduct booklet?
4. Whose letter is inside the front cover of the Code of Conduct?
5. How many hippopotamuses are in the Code of Conduct?
6. If you "Cut Along Dotted Line" on the Code of Conduct back cover, what do you get?

Answer the following questions using this week's Compliance Capsules:

7. What "doctor" writes the Compliance Capsules?
8. Who is really Dr. R.U. Compliant?
9. To whom are Compliance Capsules prescribed?
10. What is Dr. Compliant's prescription?

Answer the following questions using Policy Manager on the NRHS intranet:

11. How do you get to the Compliance policies in Policy Manager?
12. How many Compliance policies are listed?
13. What is the policy number of the Compliance Officer policy?
14. What document does not have a policy number?
15. The "Compliance Education" policy refers to what related policy?
16. What term is defined in the "Conflicts of Interest" policy?

The Compliance Carnival is in town!

NRHS HIPAA Privacy & Security Week
May 21 - 25, 2012

I SPY & Find Puzzle

Can you find the 22 HIPAA-related words hidden in the puzzle? Each word is in a straight line and is forward, backward, horizontally, vertically or diagonally. Circle the words as you find them and return the completed puzzle to Shawn Stone (Compliance Department, Porter Campus; fax: 307-1168) by 12 noon Friday, 5/25/12. All correctly answered puzzles will be entered in the NRHS HIPAA Privacy & Security Week grand prize drawing on Friday.

Grand prize Two tickets to Warren IMAX Theater.

A	C	C	O	U	N	T	A	B	I	L	I	T	Y	Q	A	W	P	Z	N
S	A	E	X	D	R	C	F	T	V	G	Y	B	H	U	N	J	R	O	I
M	K	P	O	L	P	P	P	H	I	L	O	K	M	I	J	N	I	U	H
H	B	Y	I	G	B	V	T	F	C	R	A	D	X	E	S	T	V	Z	W
E	A	Q	Z	H	C	R	B	M	N	V	X	M	L	J	A	G	A	D	A
A	S	A	F	N	E	C	E	S	S	A	R	Y	E	M	H	K	C	P	I
L	C	Y	R	A	R	W	Q	A	E	T	U	O	R	N	A	B	Y	E	G
T	I	K	M	O	U	Q	S	U	C	W	Y	O	B	D	D	F	H	J	S
H	L	N	P	R	S	T	T	V	X	H	F	Z	E	X	D	M	R	C	E
U	P	K	Q	A	O	W	H	Z	S	N	Q	B	M	N	V	X	E	F	C
Z	O	B	T	V	L	G	N	O	I	T	A	C	I	F	I	T	O	N	I
D	R	A	Y	B	C	H	U	N	R	J	I	N	E	V	T	F	C	R	T
P	T	S	M	K	S	I	K	M	O	I	S	O	L	C	P	P	L	O	C
E	A	S	K	M	I	L	N	P	R	U	Z	U	Q	P	I	W	O	E	A
I	B	I	S	R	D	U	T	Y	R	L	A	A	K	S	J	T	D	H	R
H	I	F	G	E	Z	M	X	A	N	C	D	E	T	C	E	T	O	R	P
W	L	B	H	U	C	B	N	X	D	R	V	S	J	I	I	K	M	N	X
A	I	K	M	I	S	C	A	O	L	P	U	T	F	C	O	L	N	P	R
I	T	D	X	E	E	M	A	M	T	F	S	B	M	N	B	N	K	Q	A
G	Y	T	I	R	U	C	E	S	P	P	E	Y	M	I	N	I	M	U	M

ACCESS
ACCOUNTABILITY
ACT
AMENDMENT
AUTHORIZATION
BREACH
DISCLOSURE
HEALTH
HIPAA
INFORMATION
INSURANCE
MINIMUM
NECESSARY
NOTICE
NOTIFICATION
PHI
PORTABILITY
PRACTICES
PRIVACY
PROTECTED
SECURITY
USE

NAME: _____ **DEPT.:** _____ **PHONE:** _____

DEADLINE: To be eligible for the drawing, puzzles are due to Shawn Stone no later than 12 noon on Friday, May 25th.

MIDAS+ Seeker
11/6/2012
08:56:35AM

BIOGRAPHICAL WORKSHEET

Manning, Valerie B. DO **ID Number:** MANNVA

Office Addresses

Practice Name: Manning, Valerie, DO
Address: 2625 SW 119th St., Suite A
Room/Suite #:
City: Oklahoma City
State: OK
Zip: 73170
Country:

Address Type: Primary Practice
Practice Phone: 692-4777 **Ext:**
Direct Line: **Ext:**
Practice Fax: 692-4778
Direct Fax:
E-mail: ronald_manning@att.net
Primary Contact:
Office Manager:

Associates

Name	Type	Practice Location	Organizations	Start Date	End Date

Board Certifications

Board: Am Osteo Board of Family Physicians
Certification: Family Medicine - General Cert
Status: Certified
Certification #: 11306
Exam Date:
Specialty in Directory: N
Start Date: 10/2002
End Date: 12/2018
Re Cert Start:
Re Cert End:
Verified: Y
Date Verified:

Health Status

Status	Type	Start Date	End Date	Verified	Date Verified
Received	INFLUENZA VACCINE 2012-2013	10/24/2012	10/24/2012	Y	

Affiliations

Name	Type of Organization	Status	Start Date	End Date	Verified	Date Verified
Deaconess Hospital	Acute Care Hospital		08/26/2002		Y	10/19/2012
Mercy Health Center	Acute Care Hospital		01/01/2002	12/31/2005	Y	09/12/2012
Integris Baptist Medical Center	Acute Care Hospital		10/01/2002	12/31/2004	Y	09/13/2012
Kindred Hospital	Acute Care Hospital		01/01/2002	12/31/2004	Y	09/28/2012

Peer References

Name	Specialty	Position	Date	Verified	Date Verified
Pamela Craven, MD				Y	09/24/2012
Alexei Prytkov, MD				Y	09/20/2012
Pamela Ghezzi, DO				Y	10/22/2012

Education/Training

Institution	Degree/Program	Major/Specialty	Start Date	End Date	Verified	Date Verified
University of Health Sciences	MEDICAL EDUCATION		01/1995	01/1999	Y	
Hillcrest Health Center	INTERNSHIP	Rotating	01/1999	01/2000	Y	
St. Michael Hospital	RESIDENCY	Family Medicine	01/2000	01/2002	Y	